

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27001

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELMER W. DOSS

2. Date of Death

Month Day Year

AUGUST 22 2000

3. Time of Death

1730

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

317-09-1580

6. Sex

M 20 F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

MARCH 18, 1910

9. Birthplace (State or Foreign Country)

INDIANA

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELLICOTT CITY

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

5113 MORNINGSIDE LANE

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOREMAN

16b. Kind of Business/Industry

AUTOMOBILE-MANUFACTURE

17. Father's Name (First, Middle, Last)

THOMAS EDWARD DOSS

18. Mother's Name (First, Middle, Maiden Surname)

ANNA MARIE DROSTE

19a. Informant's Name/Relationship (Type, Print)

WALTER DOSS (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5113 MORNINGSIDE LANE, ELLICOTT CITY, MD 21043

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DELTONA MEMORIAL CEMETERY

Date

8/24/00

20c. Location - City or Town, State

ORANGE CITY, FLORIDA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Della Noce & Sons Funeral Home
322 S. High St. Baltimore Md., 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UROSEPSIS

CHRONIC RENAL FAILURE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

[Signature] MEDICAL DOCTOR

29c. License number

P12597

29d. Date signed (Month, Day, Year)

AUGUST 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WORLALI NUTAKOR, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME DOSS, ELMER

Division of Vital Records, P.O. Box 68760,

SD 17 1 22

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27002

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Ellen Fountain		2. Date of Death Month Day Year Aug. 24, 2000		3. Time of Death 1:22 AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-05-3103	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 7, 1912
	9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Baltimore	
	10c. City, Town or Location Catonsville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 2 Winesap Court		10f. Zip Code 21228		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator	
	16b. Kind of Business/Industry Telephone Company		17. Father's Name (First, Middle, Last) George Berger		18. Mother's Name (First, Middle, Maiden Surname) Mary Matthews	
	19a. Informant's Name/Relationship (Type, Print) Joan Ianniello/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1906 Forest Court, Timonium, Maryland 21093			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State 8/26/00 Elkridge, Maryland	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Left hemispheric stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. 8 days Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D25205		
		29d. Date signed (Month, Day, Year) August 24, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley, GPMC 6701 N. Charles St., Balto. Md 21204						
31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27003

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John M. Finnerty		2. Date of Death Month Day Year August 22 2000		3. Time of Death 3:10 P.M.
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 217-01-2641	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) NOV 4, 1921		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 705 204th Street		10f. Zip Code 21122		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer, LOCOMOTIVE		16b. Kind of Business/Industry RAILROAD	
17. Father's Name (First, Middle, Last) John C. Finnerty		18. Mother's Name (First, Middle, Maiden Surname) Anna M. Schaeffer			
19a. Informant's Name/Relationship (Type, Print) Mayllison Dawson / sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 Eliot Road Pasadena, MD 21122			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 8/23/2000 Baltimore, MD	
21. Signature of Funeral Service licensee 		22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mt Road Pasadena, MD 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.					
Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CANCER Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D43977		29d. Date signed (Month, Day, Year) August 22 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ayden Drenth, 301 Hospital Drive, Glen Burnie, MD 21061.					
31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

upside of page 2, 10/10/10

INVESTIGATION INTO
BURNING

upside of page 2, 10/10/10

DETAILS

10/10/10

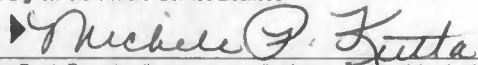
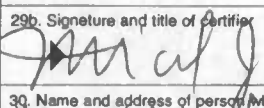

upside of page 2, 10/10/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27004

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Carlough Faulkner				2. Date of Death Month August Day 23 Year 2000				3. Time of Death 3:40 am	
	4a. Facility Name (If not institution, give street and number) Ginger Cove				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 144-03-0569		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 14, 1910		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1311 River Crescent Drive				10f. Zip Code 21401				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (14 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Supervisor				16b. Kind of Business/Industry Utility		
17. Father's Name (First, Middle, Last) Harry Faulkner				18. Mother's Name (First, Middle, Maiden Surname) Lillian Carlough						
19a. Informant's Name/Relationship (Type, Print) Jonathan Faulkner (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Indian Lane, Annapolis, MD 21403						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Mem.				20c. Location - City or Town, State Paramus, NJ		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CVA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 7-100										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 011438		29d. Date signed (Month, Day, Year) August 23 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaRocca 119 Indian Lane Annapolis, MD 21401-1077										
31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27005

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZA JANE GURRY

2. Date of Death

Month Day Year
AUGUST 20, 2000

3. Time of Death

02:12 A.M.

4a. Facility Name (If not institution, give street and number)

1504 MOUNTMOR COURT

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214 30 3193

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 14, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1504 Mountmor Court

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

ELIJAH WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Foster

19a. Informant's Name/Relationship (Type, Print)

Maurice Gurry 1son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1504 Mountmor Court Baltimore, Md 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

mt Calvary Cemetery

Date

8-26-2000

20c. Location - City or Town, State

Brooklyn, Maryland

21. Signature of Funeral Service Licensee

Debra Harris

22. Name and Address of Facility

CHATHAM - Harris Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
INSPECTION

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

SCENE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Debra Harris

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

Debra Harris

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

724



1
6




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27006

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry John Glaeser Jr.				2. Date of Death Month Day Year AUGUST 24 2000		3. Time of Death 04:30													
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE				4b. City, Town, or Location of Death Baltimore		4c. County of Death City													
Funeral Director	5. Social Security Number 213-28-9707		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) MAY 22, 1928													
	9. Birthplace (State or Foreign) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Manchester													
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
	10e. Street and Number 2825 Hilltop Drive				10f. Zip Code 21102		10g. Citizen of What Country? U.S.A.													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist		16b. Kind of Business/Industry Self Employed															
	17. Father's Name (First, Middle, Last) Henry John Glaeser Sr.				18. Mother's Name (First, Middle, Maiden Surname) Julia Margaret Zajdel															
	19a. Informant's Name/Relationship (Type, Print) Barbara L. Glaeser - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Hilltop Dr. Manchester, Md. 21102															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Lutheran Cem. Aug. 28, 2000		20c. Location - City or Town, State Manchester, Md.															
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. PNEUMONIA</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 1 week</td> </tr> <tr> <td>b. MYOCARDIAL INFARCTION</td> <td>Due to (or as a consequence of):</td> <td>2 weeks</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week	b. MYOCARDIAL INFARCTION	Due to (or as a consequence of):	2 weeks	c. _____	Due to (or as a consequence of):		d. _____	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 week																	
	b. MYOCARDIAL INFARCTION	Due to (or as a consequence of):	2 weeks																	
	c. _____	Due to (or as a consequence of):																		
	d. _____	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION, HYPERTENSION, ASTHMA, EMPHYSEMA, BLADDER CANCER, BONE CANCER																				
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier  MD				29c. License number 19678		29d. Date signed (Month, Day, Year) AUGUST 24, 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISTIN E. ERICKSON 2401 WEST BELVEDERE BALTIMORE, MD 21215																				
31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature 																		
State Registrar																				

ORIGINAL

Very truly yours,

Wm. L. Garrison

My dear Sir,

7

1840-1841

Enclosed

Enclosed

.....

Yours

Yours

Wm. L.

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

Wm. L. Garrison

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AMEND ITEMS: #10 10B, D 19B PER F.H. G787 9-12-00 WR

AMEND ITEM: #10F PER INFORMANT G787 9-11-00 WR

Certificate of Death

Reg. No.

00 27007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fred Vincent Gump, Sr.				2. Date of Death Month Day Year August 24, 2000		3. Time of Death 10:45 PM		
	4a. Facility Name (If not institution, give street and number) 603 Gibson Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 171-18-2106		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Feb 18, 1917		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County NA		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 603 Gibson Road		10f. Zip Code 21228 21229		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) Charles Justin Gump		18. Mother's Name (First, Middle, Maiden Surname) Nettie Henderson	
19a. Informant's Name/Relationship (Type, Print) Sarah Catherine Gump / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Gibson Road, Baltimore, Maryland 21228 21229		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc.		20c. Location - City or Town, State 8/28/2000 Baltimore, Maryland	
21. Signature of Funeral Service Licensee Ann Y. Zink		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cancer Stomache Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death 2 months	
23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Stomache Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Rafat Y. Girgis		29c. License number D31726		29d. Date signed (Month, Day, Year) 8/25/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAAFAT Y. GIRGIS		31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature B. Spauls		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 724 Maiden Choice LA. Catonsville MD			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

441

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27008

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Douglass James Grant</i>						2. Date of Death Month <i>August</i> Day <i>22</i> Year <i>2000</i>		3. Time of Death <i>23:30</i>		
	4a. Facility Name (If not institution, give street and number) <i>Good Samaritan Hospital</i>						4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>Baltimore City</i>		
Funeral Director	5. Social Security Number <i>215-28-2835</i>		6. Sex <i>1 Male 2 Female</i>		7. Age (in yrs. last birthday) <i>67</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>April 10, 1933</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
	Usual Residence of Decedent										
10a. State <i>MD</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <i>1 Yes 2 No</i>			
10e. Street and Number <i>6601 Collindale Apt C</i>				10f. Zip Code <i>21234</i>		10g. Citizen of What Country? <i>U.S.A.</i>					
11. Marital Status <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>		12. Was Decedent Ever in U.S. Armed Forces? <i>1 Yes 2 No</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 Yes 2 No Specify:</i>		14. Race - American Indian, Black, White, etc. <i>Specify: Black</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> College (1-4 or 5+) <i>N/A</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Labor</i>		16b. Kind of Business/Industry <i>Custodian Alliance Inc.</i>					
17. Father's Name (First, Middle, Last) <i>Sherman Grant</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Lula Chamberlain</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Mae Davis</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4403 Miravia Rd. Apt 6 Balto. Md. 21206</i>							
20a. Method of Disposition <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Greenmont Cem.</i>		20c. Location - City or Town, State <i>Baltimore, Md.</i>		20d. Date <i>8/25/2000</i>			
21. Signature of Funeral Service Licensee <i>Patricia Butts</i>				22. Name and Address of Facility <i>Beths Funeral Home 1129 N. Caroline St. Balto. Md. 21213</i>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>SEPSIS</i> Due to (or as a consequence of):</p> <p>b. <i>AIDS</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <i>1 Yes 2 No 3 Probably 4 Unknown</i>											
24a. Was an autopsy performed? <i>1 Yes 2 No</i>											
24b. Were autopsy findings available prior to completion of cause of death? <i>1 Yes 2 No</i>											
25. Was case referred to medical examiner? <i>1 Yes 2 No</i>				26. Place of Death (Check only one) Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 8 Other (Specify)</i>							
27. Manner of Death <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <i>1 Yes 2 No</i>		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</i>											
29b. Signature and title of certifier <i>Dr. [Signature] M.D.</i>				29c. License number <i>5-3356</i>		29d. Date signed (Month, Day, Year) <i>August 22 2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ORI TEUK M.D.</i>											
31. Date filed (Month, Day, Year) <i>AUG 25 2000</i>				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AT

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene 00 27009

Certificate of Death

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Lillian Gillis

2. Date of Death Month 8 Day 19 Year 00 Time of Death 1:00 PM

3. Time of Death

4a. Facility Name (If not Institution, give street and number) GEC-R 4b. City, Town, or Location of Death RANDOLPH 4c. County of Death BALTIMORE

5. Social Security Number 220-30-672 6. Sex 1 ☐ M ☒ F 7. Age (In yrs. last birthday) 86 Yrs. 8. Date of Birth (Month, Day, Year) 7-12-1914 9. Birthplace (State or Foreign Country) NC

10a. State Md. 10b. County Baltimore 10c. City, Town or Location Catonsville 10d. Inside City Limits ☐ Yes ☒ No

11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) 12th Grade 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic 16b. Kind of Business/Industry Private Families

17. Father's Name (First, Middle, Last) Lee Gillis 18. Mother's Name (First, Middle, Maiden Surname) Lillie Douglas

19a. Informant's Name/Relationship (Type, Print) Karen Thompson friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Doe Hill Court Catonsville, Md. 21228

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park Date Aug. 25 20c. Location - City or Town, State Baltimore, Md.

21. Signature of Funeral Service Licensee Herbert E. Nutter 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): NECROTISING CLOSTRIDIUM SOFT TISSUE INFECTION

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM; HTN; RENAL FAILURE

23c. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Herbert E. Nutter 29c. License number DS2360 29d. Date signed (Month, Day, Year) 8/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KURBIN SANDHU 1838 GREEN TREE RD SUITE 300 PLEASANT 2106

31. Date filed (Month, Day, Year) AUG 25 2000 32. Registrar's Signature [Signature]

State Registrar

ORIGINAL

W. S. T. 111

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27010

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angelo M. Giles				2. Date of Death Month: August Day: 20 Year: 2000		3. Time of Death 11:30 am									
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel									
Funeral Director	5. Social Security Number 220-57-2062		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 19		8. Date of Birth (Month, Day, Year) July 1, 2000									
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie									
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 7826 Woodside Terrace, #201		10f. Zip Code 21061		10g. Citizen of What Country? USA										
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A												
17. Father's Name (First, Middle, Last) Keven Mark Giles				18. Mother's Name (First, Middle, Maiden Surname) Carleen Annette Ginn												
19a. Informant's Name/Relationship (Type, Print) Carleen A. Giles (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7826 Woodside Terrace, #201, Glen Burnie, MD 21061												
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 08/25 2000		20c. Location - City or Town, State Baltimore, MD										
21. Signature of Funeral Service Licensee <i>Michelle G. Kutta</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Extensive Gastrointestinal Hemorrhage</td> <td>1 day</td> </tr> <tr> <td>b. Gastrointestinal Dysfunction</td> <td>50 days</td> </tr> <tr> <td>c. Chronic Pulmonary Insufficiency</td> <td>20 days</td> </tr> <tr> <td>d. Grade IV Intraventricular Hemorrhage</td> <td>47 days</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Extensive Gastrointestinal Hemorrhage	1 day	b. Gastrointestinal Dysfunction	50 days	c. Chronic Pulmonary Insufficiency	20 days	d. Grade IV Intraventricular Hemorrhage	47 days
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Extensive Gastrointestinal Hemorrhage	1 day														
	b. Gastrointestinal Dysfunction	50 days														
	c. Chronic Pulmonary Insufficiency	20 days														
	d. Grade IV Intraventricular Hemorrhage	47 days														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier <i>Yann-Lin M.D.</i>				29c. License number D47158		29d. Date signed (Month, Day, Year) August 22, 2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yann-Lin Lin, M.D. 8218 WISCONSIN AVE, SUITE 404, BETHESDA, MD 20814																
31. Date filed (Month, Day, Year) AUG 25 2000				32. Registrar's Signature <i>B. Sparks</i>												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27011

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILTON GARLAND		2. Date of Death Month Day Year AUGUST 21, 2000		3. Time of Death 9:15 AM
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 218-32-2461	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) DEC. 23, 1925		9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County BALTIMORE
	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10a. Street and Number 6507 STEERFORTH COURT		10f. Zip Code 21209		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: NAVY		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER
	16b. Kind of Business/Industry MUSIC STORE		17. Father's Name (First, Middle, Last) MORRIS GINSBERG		18. Mother's Name (First, Middle, Maiden Surname) MARY SILVERMAN
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY GARLAND / WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6507 STEERFORTH COURT - BALTIMORE, MD 21209		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BNAI ISRAEL CEMETERY		20c. Location - City or Town, State 8/24/00 BALTIMORE, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				
	a. SEPTIC SHOCK Due to (or as a consequence of):				
	b. CHEMOTHERAPY Due to (or as a consequence of):				
	c. LUNG CANCER - METASTATIC Due to (or as a consequence of):				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number D23964		
	29d. Date signed (Month, Day, Year) AUGUST 22, 2000				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY D. GABER, M.D. 2360 WEST JOPPA ROAD #302 LUTHERVILLE, MD 21093				
	31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27012

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RITA GALLAGHER				2. Date of Death Month Day Year AUG 18 2006				3. Time of Death 0655	
	4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-36-7445		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) MAY 14, 1916		9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 732 S. DECKER AVE.										
10f. Zip Code 21224										
10g. Citizen of What Country? USA										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: WHITE										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH College (1-4 or 5+)										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER										
16b. Kind of Business/Industry OWN HOME										
17. Father's Name (First, Middle, Last) TIMOTHY JOSEPH O'NEILL										
18. Mother's Name (First, Middle, Maiden Surname) MARY JANE KEOGH										
19a. Informant's Name/Relationship (Type, Print) JAMES F. GALLAGHER/SON										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7944 ST. MONICA DR., BALTIMORE, MD. 21222										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEM.										
20c. Location - City or Town, State 8/22/00 BALTIMORE, MD.										
21. Signature of Funeral Service Licensee <i>Charles S. Zeiler</i>										
22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease 15 yrs Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury M										
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Joseph Costa, MD</i>										
29c. License number D42634										
29d. Date signed (Month, Day, Year) AUG 18, 2006										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH COSTA 301 ST PAUL PLACE BALTIMORE MD 21202										
31. Date filed (Month, Day, Year) AUG 25 2006										
32. Registrar's Signature <i>Sparks</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27013

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Frank P. Helowicz</u>				2. Date of Death Month <u>August</u> Day <u>22</u> Year <u>2000</u>		3. Time of Death <u>12:20pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Mercy Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>City</u>	
Funeral Director	5. Social Security Number <u>217-09-7643</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>80</u> Yrs.	If Under 1 Year Months <u> </u> Days <u> </u>	If Under 24 Hrs. Hours <u> </u> Min. <u> </u>	8. Date of Birth (Month, Day, Year) <u>10/2/19</u>	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>
	Usual Residence of Decedent							
10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTIMORE</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <u>1728 FLEET STREET</u>				10f. Zip Code <u>21231</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WWII</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u> </u>		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>MASTER SHEETMETAL CRAFTSMAN</u>		16b. Kind of Business/Industry <u>TELEDYNE</u>		
17. Father's Name (First, Middle, Last) <u>PETER HELOWICZ</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>ANNA BOGDON</u>				
19a. Informant's Name/Relationship (Type, Print) <u>MADELINE HELOWICZ/ WIFE</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1728 FLEET ST. BALTIMORE, MD. 21231</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u> </u>				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>ST. STANISLAUS CEME.</u>		Date <u>8/26</u>		20c. Location - City or Town, State <u>BALTO., MD.</u>
21. Signature of Funeral Service Licensee <u>Eugene J. Kaczorowski</u>				22. Name and Address of Facility <u>KACZOROWSKI FUNERAL HOME P.A.</u> <u>1201 DUNDALK AVE. BALTO., MD. 21222</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>COPD</u> Due to (or as a consequence of): c. <u>Silicosis</u> Due to (or as a consequence of): d. <u> </u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <u>3 weeks</u> <u>years</u> <u>years</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Artrial Fibrillation</u> <u>malnutrition</u> <u>Disseminated Herpes Zoster</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u> </u>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u> </u>		28b. Time of Injury <u> </u> M <u> </u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u> </u>
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u> </u>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <u> </u>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>Karen A. Kaczorowski, MD</u>				29c. License number <u>D40744</u>		29d. Date signed (Month, Day, Year) <u>August 22, 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>K.A. Kaczorowski, MD, Mercy Hospital, 1001 St Paul Place, Baltimore, MD 21202</u>								
31. Date filed <u>Aug 26, 2000</u>				32. Registrar's Signature <u> </u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27014

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angela Grace Hoffnagle				2. Date of Death Month Day Year August 22, 2000		3. Time of Death 12:45 p.m.	
	4a. Facility Name (If not institution, give street and number) 100 First Ave.				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 179-20-8895	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 23, 1929		9. Birthplace (State or Foreign Country) Bonneauville, Pa.
	Usual Residence of Decedent							
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Reisterstown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 100 First Ave.				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Homemaking		
17. Father's Name (First, Middle, Last) Thomas Ambrose Myers				18. Mother's Name (First, Middle, Maiden Surname) Bertha M. Wachter				
19a. Informant's Name/Relationship (Type, Print) Alicia Ullrich - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Cedar St. Gettysburg, Pa. 17325				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Conception Cem.		Date Aug. 26, 2000		20c. Location - City or Town, State New Oxford, Pa.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 1/2 yr
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D35398		29d. Date signed (Month, Day, Year) 8-23-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 S. Conte Street Westminster, MD 21157								
31. Date filed (Month, Day, Year) AUG 25 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

111

5. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 8

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$$-2\pi i \int_{\mathbb{R}^n} \frac{1}{|x|} \delta(x) dx = -2\pi i \int_{\mathbb{R}^n} \frac{1}{|x|} \delta(x) dx$$

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27015

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Theima</i> | | 2. Date of Death
Month <i>August</i> Day <i>20</i> Year <i>2000</i> | | 3. Time of Death
<i>6:38 pm</i> |
| | 4e. Facility Name (If not institution, give street and number)
<i>University of Maryland Medical System</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>n/a</i> |
| Funeral
Director | 5. Social Security Number
<i>218-10-5764</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
<i>81</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<i>Apr 26, 1919</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>n/a</i> | | 10c. City, Town or Location
<i>Baltimore</i> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
<i>106 South Poppleton Street</i> | | | 10f. Zip Code
<i>21201</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
<i>White</i> | | Specify: | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>College</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Teacher's Aide</i> | | 16b. Kind of Business/Industry
<i>State of Maryland</i> | |
| 17. Father's Name (First, Middle, Last)
<i>Charles Brooks</i> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Emmitt (Unknown)</i> | | |
| 19e. Informant's Name/Relationship (Type, Print)
<i>Allan Crosby / son</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2216 Hammonds Ferry Road, Lansdowne, Maryland 21227</i> | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Loudon Park Cemetery</i> | | 20c. Location - City or Town, State
<i>8/24/2000 Baltimore, Maryland</i> | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
<i>Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. <i>Myocardial Infarction</i>
Due to (or as a consequence of): | | | | | |
| b. <i>Cerebrovascular Accident</i>
Due to (or as a consequence of): | | | | | |
| c.
Due to (or as a consequence of): | | | | | |
| d.
Due to (or as a consequence of): | | | | | |
| 23b. Old tobacco use contributes to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>13116</i> | | 29d. Date signed (Month, Day, Year)
<i>August 22, 2000</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Jorge Uribe 22 South Greene Street, Baltimore, Maryland 21201</i> | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27016

| | | | | | | | |
|---|---|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VIRGINIA LEE HOYLE | | | 2. Date of Death
Month AUGUST Day 22 Year 2000 | | 3. Time of Death
11:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Bon Secours Hospital | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-58-1044 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUN 22, 1954 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
2114 Wilkens Avenue | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cosmotologist | | 16b. Kind of Business/Industry
Beauty Care | | |
| 17. Father's Name (First, Middle, Last)
Dale Richard Paul | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Mary Brooke | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lillian M. Paul - Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2114 Wilkens Ave., Balto., Md. 21223 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Grdns. | | Date
8/28/00 | | 20c. Location - City or Town, State
Timonium, Md. | |
| 21. Signature of Funeral Service Licensee
<i>Kim Schlangen M.D.</i> | | | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. JAUNDICE
Due to (or as a consequence of):
b. HEPATO-RENAL FAILURE
Due to (or as a consequence of):
c. ETOH ABUSE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D24100 | | 29d. Date signed (Month, Day, Year)
08-23-2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M.L. PRABHAKAR M.D., 300 ARMORY PLACE BAL, MD 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

GEORGE HORNER
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F P. 00 G786 8-31-00 WR.

Certificate of Death

Reg. No.

00 27017

| | | | | | |
|---|---|--|--|--|------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George P. Horner | | 2. Date of Death
Month AUGUST Day 21 Year 2000 | | 3. Time of Death
11:58 A |
| | 4a. Facility Name (If not institution, give street and number)
520 S. NEWKIRK ST. | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a |
| Funeral
Director | 5. Social Security Number
217-66-2574 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
36 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
12-4-1963 | | 9. Birthplace (State or Foreign Country)
Balto. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD. | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
520 South Newkirk St. | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
carpenter | | 16b. Kind of Business/Industry
trade | |
| 17. Father's Name (First, Middle, Last)
George G. Horner | | 18. Mother's Name (First, Middle, Maiden Surname)
Darlene Tharle | | | |
| 19a. Informant's Name/Relationship (Type, Print)
George G. Horner | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7872 A. West Riverside Drive-Pasadena, Md. 21122-3834 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore-Washington Crem. | | 20c. Location - City or Town, State
Laurel, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home
Southwest, Inc.-Pratt and Stricker St. Balto. Md. | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
ALCOHOL AND NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
FOUND: 8-21-00 | | 28b. Time of Injury
UNKNOWN | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
520 S. NEWKIRK
BALTIMORE CITY, MARYLAND | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | |
| 29d. Date signed (Month, Day, Year)
AUGUST 22, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27018

RENA HUDSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Rena B. Hudson | | | | | | 2. Date of Death
Month Day Year
August 21 2000 | | 3. Time of Death
609 AM | |
| 4a. Facility Name (If not institution, give street and number)
Villa St Michael | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | |
| 5. Social Security Number
246-30-2048 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
10-6-1922 | | 9. Birthplace (State or Foreign Country)
N.C. | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
2501 Violet Avenue | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U S A | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th grade N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Avon Representative | | | 16b. Kind of Business/Industry
Avon | | |
| 17. Father's Name (First, Middle, Last)
Sam Smith | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Silann Corper | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rowena Smith - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2501 Violet Avenue Apt 706 N Baltimore, Md 21215 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
8-25-00 | | 20c. Location - City or Town, State
Baltimore, Md | | | |
| 21. Signature of Funeral Service Licensee
June A. Thompson | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. FAILURE TO THRIVE
Due to (or as a consequence of):
b. OROPHARYNGEAL DYSPHAGIA
Due to (or as a consequence of):
c. LATE EFFECT STROKE
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEIZURE DISORDER | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Dorothy J. Pierce | | | | 29c. License number
H45931 | | | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dorothy J. Pierce 7220 Paul Heights Avenue Baltimore MD 21208 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27019

| | | | | | | | | | |
|--|--|---|---------------------------------|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John F Handley | | | | 2. Date of Death
Month 8 Day 21 Year 2000 | | 3. Time of Death
9:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
St. AGNES HOSPITAL 900 CATON AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
212-26-0844 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
8/18/1930 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore County | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
111 Leslie Avenue | | 10f. Zip Code
21236 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 Yrs. | | College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | 16b. Kind of Business/Industry
Windsor Electric | | | |
| 17. Father's Name (First, Middle, Last)
John Francis Handley, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Genevieve Etzel | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Bernadine C. Handley | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Leslie Avenue Baltimore, Md. 21236 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
8-24-00 | | 20c. Location - City or Town, State
Baltimore, Md. | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Lassam Funeral Home
7401 Belair Rd. Baltimore, Md. 21236 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | a. Coronary artery disease
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
years | |
| | | b. Due to (or as a consequence of): | | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Hyperlipidemia, Diabetes mellitus | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
P14442 | | 29d. Date signed (Month, Day, Year)
8/21/2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE DURST, M.D. 900 Caton Avenue, Baltimore, MD 21229 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
 | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27020

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred I. Heffner | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
11:19 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Brightwood Eldercare Nursing Home | | | | 4b. City, Town, or Location of Death
Brooklandville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-32-1677 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
629 Charles Street Avenue | | 10f. Zip Code
21204 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Carl Steinhagen | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Kathryn Fowler | | | | 19a. Informant's Name/Relationship (Type, Print)
Roxanne Heffner Maffitt | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
629 Charles St Avenue Towson, Maryland 21204 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation Serv. | | 20c. Location - City or Town, State
Hampstead, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Informant
 | | | | 22. Name and Address of Facility
Eline Funeral Home
11824 Reisterstown Road Reisterstown, MD 21136 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>
Due to (or as a consequence of):
b. <u>DIABETES</u>
Due to (or as a consequence of):
c. <u>HYPERTENSION</u>
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
YRS
YRS
YRS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D20333 | | | | 29d. Date signed (Month, Day, Year)
8/23/00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth M. Zonies, M.D.
1835 ARCADE RD
PIKEVILLE, MD 21208 | | | | 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
 | | | | 33. State Registrar
AUG 25 2000 | | | |

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SHARON
JOHNSON

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

00 27021

| | | | | | |
|--|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sharon Johnson | | 2. Date of Death
Month: AUGUST Day: 19 Year: 2000 | | 3. Time of Death
4:10P.M. |
| | 4a. Facility Name (If not institution, give street and number)
MERCY HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
217-70-0343 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. |
| | 8. Date of Birth (Month, Day, Year)
09-11-58 | | 9. Birthplace (State or Foreign Country)
MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
4687 Freedom Way West | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 2yrs. | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurses Aid | | 16b. Kind of Business/Industry
Nursing Home |
| 17. Father's Name (First, Middle, Last)
David Alford | | | 18. Mother's Name (First, Middle, Maiden Surname)
Laura Johnson | | |
| 19a. Informant's Name/Relationship (Type, Print)
Eva Johnson | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4687 Freedomway West Baltimore, Maryland 21213 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk.CEM. | | 20c. Location - City or Town, State
8/25/00 Randallstown, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. HYPERTENSIVE CARDIOVASCULAR DISEASE AND PART COCAINE USE | | | |
| Due to (or as a consequence of): | | b. | | | |
| Due to (or as a consequence of): | | c. | | | |
| Due to (or as a consequence of): | | d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 20, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radwytz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27022

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dolores Marie Jones

2. Date of Death

Month Day Year
Aug 21 2000

3. Time of Death

04:15 AM

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-32-9981

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 11, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Maryland BALTIMORE

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

8622 MANORFIELD ROAD

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Caucasian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FOOD SERVICE

16b. Kind of Business/Industry

BALT. CO. PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

GEORGE GUNSELMANN

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH WONDERING

19a. Informant's Name/Relationship (Type, Print)

DONALD JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8622 MANORFIELD ROAD, BALTIMORE, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

08/24/2000

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Kaczorowski

22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.

1201 Dundalk Avenue, Baltimore, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. SEPSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Hypertension
Renal Insufficiency
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William M. Matsoi

29c. License number

D 53335

29d. Date signed (Month, Day, Year)

August 21, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. William Matsoi 9000 Franklin Square Hospital Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

00-4670-025

Tamika JOYNER

JVV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PER. MEO G787 9-8-00 WR.

00 27023

AMEND ITEMS: #23 PART I, 27, 28A-F Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Tamika Joyner | | 2. Date of Death
Month Day Year
AUGUST 17, 2000 | | 3. Time of Death
10:27 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital | | 4b. City, Town, or Location of Death
Havre de Grace | | 4c. County of Death
Harford |
| Funeral
Director | 5. Social Security Number
213-47-9763 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
4 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
04 19 96 | | 9. Birthplace (State or Foreign Country)
M.D. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10e. Street and Number
3703 West Garrison Ave | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | |
| 16b. Kind of Business/Industry
N/A | | 17. Father's Name (First, Middle, Last)
Karlos Williams | | 18. Mother's Name (First, Middle, Maiden Surname)
Carla Joyner | |
| 19a. Informant's Name/Relationship (Type, Print)
Carla B. Joyner-Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3703 West Garrison Ave, Baltimore Md 21215 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
8/26/00 Randallstown, Md | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21215 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8-17-00 | |
| 28b. Time of Injury
9:30 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT ASPIRATED CAT LITTER | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOUSE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
315 WOODLAND GREEN CT., ABERDEEN, MD | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
AUGUST 18, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Alan Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27024

| | | | | | | | | |
|---|--|---|---|---|---|--|-------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kenneth B. Jones | | | | 2. Date of Death
Month Day Year
August 21 2000 | | 3. Time of Death
8:21 PM | |
| | 4a. Facility Name (If not institution, give street and number)
10121 Frederick Road | | | | 4b. City, Town, or Location of Death
Ellicott City | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
219-30-6427 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 03 1935 | | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Ellicott City | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
10121 Frederick Road | | | | 10f. Zip Code
21042 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Store Manager | | 16b. Kind of Business/Industry
Retail Grocery | | |
| 17. Father's Name (First, Middle, Last)
Francis Jones | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Macie | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rosalie Jones (spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10121 Frederick Rd., Ellicott City, MD. 21042 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview Memorial Park | | Data
Aug. 25 2000 | | 20c. Location - City or Town, State
Sykesville, Maryland | | |
| 21. Signature of Funeral Service Counselor
[Signature] | | | | 22. Name and Address of Facility
Stallings Funeral Home, P.A.
3111 Mountain Rd., Pasadena, MD. 21122 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Adenocarcinoma of Unknown Primary with Liver Metastasis</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
13 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D38509 | | 29d. Date signed (Month, Day, Year)
August 22 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nicholas Rottschalk 11065 Little Patuxent Pkwy Columbia MD 21044 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
[Signature] | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27025

| | | | | | | | | |
|--|--|---|---|---|--|--|----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCES GLOWINSKI JACOBSEN | | | | 2. Date of Death
Month Day Year
August 24 2000 | | 3. Time of Death
6:10 am | |
| | 4a. Facility Name (If not institution, give street and number)
STELLA MARIS | | | | 4b. City, Town, or Location of Death
TIMONIUM | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-16-5639 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV. 29, 1907 | | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
FULLERTON | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
6805 BEECH AVENUE | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| 17. Father's Name (First, Middle, Last)
CASIMIR GLOWINSKI | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA SZYMKOWIAK | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
IRENE NOLL - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6805 BEECH AVENUE BALTIMORE, MARYLAND 21206 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY REDEEMER CEMETERY | | Date
8/26/00 | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Elizabeth Selinski</i> | | | | 22. Name and Address of Facility
JOHN C. MILLER, INC
6415 BELAIR ROAD BALTIMORE, MARYLAND 21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Cardiomyopathy</i>

Due to (or as a consequence of):
<i>Generalized atherosclerosis</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Insomnia</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of Certifier
<i>Dr. Eddie Nakhuda</i> | | | | 29c. License number
D 15504 | | 29d. Date signed (Month, Day, Year)
8.24.00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
<i>Benita B Sparks</i> | | | | | | |

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

NAME: JACOBSEN, FRANCES

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27026

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--------------------------|---|--|--|--------------------------|---|--|--|--|--|---------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY KARL | | | 2. Date of Death
Month Day Year
August 19 2000 | | | 3. Time of Death
11:34 A.M. | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
7829 Wynbrook Road | | | 4b. City, Town, or Location of Death
Colgate | | | 4c. County of Death
Baltimore | | | | | | | | |
| Funeral
Director | 5. Social Security Number
218-01-9075 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 22 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
Baltimore | | 10c. City, Town or Location
Colgate | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
7829 Wynbrook Road | | | | 10f. Zip Code
21224 | | | 10g. Citizen of What Country?
USA | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) 6th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
own home | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Sweeder | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Kantorski | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margie Mollohan / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8009 Bank Street Baltimore Md. 21224 | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | | 20c. Date
8/24/2000 | | 20d. Location - City or Town, State
Baltimore MD | | | | | | |
| 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
Partial
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier
Rogaine Melchior | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 20, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Margaret A. Kohn 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27027

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Carmella Larkin</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>22</i> Year <i>2000</i> | | 3. Time of Death
<i>6:40 pm</i> | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>University of Maryland Medical System</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death | | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>219-30-1054</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>65</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>12-6-1934</i> | | | | | | | |
| | 10a. State
<i>Md.</i> | | 10b. County
<i>Balto.</i> | | 10c. City, Town or Location
<i>Woodlawn</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
<i>7021 Dogwood Road</i> | | | | 10f. Zip Code
<i>21244</i> | | 10g. Citizen of What Country?
<i>USA</i> | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>1</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>legal secretary</i> | | 16b. Kind of Business/Industry
<i>U.S. Government-law</i> | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>Sylvester A. Gianforte</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Jeannette Gugliuzza</i> | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Timothy O. Larkin-husband</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>7021 Dogwood Road-Woodlawn, Md. 21244</i> | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Crestlawn Memorial Gardens</i> | | 20c. Location - City or Town, State
<i>8-26-2000 Marriottsville, Md.</i> | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> <i>MO1142</i> | | | | 22. Name and Address of Facility
<i>Witzke Funeral Homes, Inc.</i>
<i>1630 Edmondson Ave., Catonsville, Md.</i> | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <i>Cor pulmonale</i>
Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____
Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____
Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____
Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <i>Cor pulmonale</i>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. _____
Due to (or as a consequence of): | c. _____
Due to (or as a consequence of): | d. _____
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <i>Cor pulmonale</i>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | |
| | b. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| | c. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| | d. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Congestive heart failure</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>Elyse Michelson</i> | | | 29c. License number
<i>13083</i> | | 29d. Date signed (Month, Day, Year)
<i>August 23, 2000</i> | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Elyse Michelson 22 South Greene Street Baltimore, Maryland 21201</i> | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27028

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Hattie Little | | | | 2. Date of Death
Month 8 Day 23 Year 2000 | | 3. Time of Death
5:25 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
215-09-5323 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 17, 1917 | | |
| | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore County | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4718 Ridge Rd. | | | | 10f. Zip Code
21236 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher's Aide | | 16b. Kind of Business/Industry
Baltimore County Public Schools | | | |
| 17. Father's Name (First, Middle, Last)
Frank Beaumont Foard | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Virginia Smith | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Shirley M. Little | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3109 Catrina Lane Annapolis, Maryland 21403 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
8-26-2000 | | 20c. Location - City or Town, State
Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Md. 21236 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Intracranial Hemorrhage
Due to (or as a consequence of):
Hypertension
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
dementia
Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
dementia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and Title of Certifier
 | | | | 29c. License number
D0053277 | | 29d. Date signed (Month, Day, Year)
8/23/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter Stengel 64 Franklin St Annapolis MD 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
 | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27029

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Malte Fabian Lindgren | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
11:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
719 Maiden Choice Lane, BR 105 | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
078-10-9733 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 9, 1909 | |
| | 9. Birthplace (State or Foreign Country)
Sweden | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
719 Maiden Choice Lane, BR105 | | 10f. Zip Code
21228 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Painter | | | | 16b. Kind of Business/Industry
Contractor | | 17. Father's Name (First, Middle, Last)
Sven Lindgren | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Katrina UNK. | | | | 19a. Informant's Name/Relationship (Type, Print)
Olga S. Lindgren/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
719 Maiden Choice Lane, BR105 Catonsville, MD 21228 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 8/25/00 | | 20c. Location - City or Town, State
Baltimore, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
George E. MacNabb | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Scott Poulton | | 29c. License number
D40012 | |
| | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Scott Poulton, M.D. 700 Geipe Road Catonsville, MD 21228 | | 31. Date filed (Month, Day, Year)
AUG 25 2000 | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
S. Sparks | | | | 33. Date of Death
August 23, 2000 | | 34. Registrar's Signature
S. Sparks | |
| | 35. Date of Death
August 23, 2000 | | | | 36. Registrar's Signature
S. Sparks | | 37. Date of Death
August 23, 2000 | |

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO

786 9-6-00 WB
Certificate of Death

Reg. No.

00 27030

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Craig Leisenring

2. Date of Death

Month Day Year
AUGUST 18 2000

3. Time of Death

5:35 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

220-92-6914

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 3, 1966

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

824 Sunstrand Road

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Robert W. Leisenring

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jane Cardwell

19a. Informant's Name/Relationship (Type, Print)

Sheila D. Leisenring Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2525 Balt. Blvd. #31, Finksburg, MD 21048

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Carroll Cremation

Date

8/22/00

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Road
Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or other failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

DIABETIC KETOACIDOSIS

a. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. H. Locke

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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amend item 31 per dvr G786 8/25/00 yg State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27031

| | | | | | |
|---|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RUTH WILMA LACKNER | | 2. Date of Death
Month Aug Day 24 Year 2000 | | 3. Time of Death
0745 |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMAKITAN HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
212-01-0225 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
98 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Dec 26, 1901 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
N/A |
| | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
3311 WOODSTOCK AVE | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY |
| | 16b. Kind of Business/Industry
Broker Firm | | 17. Father's Name (First, Middle, Last)
CARL LACKNER | | 18. Mother's Name (First, Middle, Maiden Surname)
CAROLINE FRITZENWANKER |
| | 19e. Informant's Name/Relationship (Type, Print)
Catherine Cissin | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3309 WOODSTOCK AVE BALTO MD 21213 | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OAKLAND cemetery | | 20c. Location - City or Town, State
BALTO MD. |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
HARTLEY Miller Funeral Home CHFD.
7527 HARFORD RD BALTO MD 21234 | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. atherosclerotic heart disease
Due to (or as a consequence of): | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. Coronary artery disease
Due to (or as a consequence of): | | 20 |
| | | | c. Renal failure
Due to (or as a consequence of): | | 1 |
| | | | d. atherosclerotic
Due to (or as a consequence of): | | 20 |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D37280 | | 29d. Date signed (Month, Day, Year)
8/24/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JERARD INSEL M.D. GOOD SAMAKITAN HOSPITAL | | | | | |
| 31. Date filed (Month, Day, Year)
8/24/00 | | 32. Registrar's Signature
<i>[Signature]</i>
AUG 25 2000 | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27032

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Mary C. Melone</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>14</i> , Year <i>2000</i> | | | | 3. Time of Death
<i>11:20pm</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Sinai Hospital of Baltimore</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | | | 4c. County of Death
<i>N/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>212-05-2261</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
<i>86</i> Yrs. | | 8. Date of Birth
Month <i>Oct.</i> Day <i>16</i> , Year <i>1913</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>MD</i> | | 10b. County
<i>Howard</i> | | 10c. City, Town or Location
<i>Elkridge</i> | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
<i>5865 Main Street</i> | | | | 10f. Zip Code
<i>21075</i> | | 10g. Citizen of What Country?
<i>USA</i> | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Clerk</i> | | | 16b. Kind of Business/Industry
<i>Calvert Distillery</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>George Crook</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Nellie Berrett</i> | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Margaret A. Meyer - daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>8621 South Bali Ct., Ellicott City, Md. 21043</i> | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>St. Augustines Cemetery</i> | | 20c. Location - City or Town, State
<i>Elkridge, Md.</i> | | 20d. Date
<i>8/18/00</i> | |
| | 21. Signature of Funeral Service Licensee
<i>May K. Marshall</i> | | | | 22. Name and Address of Facility
<i>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075</i> | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <i>Acute Myocardial Infarction</i>
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year)
<i>M</i> | | | | | | | | | | |
| 28b. Time of Injury
<i>M</i> | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Amy M. Dvorcek, DO</i> | | | | | | | | | | |
| 29c. License number
<i>RES000</i> | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
<i>August 24, 2000</i> | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Sinai Hospital 2401 West Belvedere Ave Baltimore, MD 21215</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | | | | | | | | | |
| 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27033

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Herman G Miller</i> | | | | 2. Date of Death
Month <i>08</i> Day <i>21</i> Year <i>00</i> | | 3. Time of Death
<i>2243</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Anne Arundel Medical Center</i> | | | | 4b. City, Town, or Location of Death
<i>Annapolis MD</i> | | 4c. County of Death
<i>A.A.</i> | |
| Funeral
Director | 5. Social Security Number
<i>570-14-4394</i> | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>89</i> Yrs. | | 6. Date of Birth (Month, Day, Year)
<i>Jan. 10, 1911</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Indiana</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Mayo</i> | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
<i>MD</i> | | | 10b. County
<i>Anne Arundel</i> | | | 10c. City, Town or Location
<i>Mayo</i> | | |
| 10d. Inade City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
<i>114 Linden Avenue</i> | | | 10f. Zip Code
<i>21106</i> | | |
| 10g. Citizen of What Country?
<i>USA</i> | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>1934-37</i> | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>1</i> College (1-4or 5+) <i>1</i> | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Ordinance Engineer</i> | | | 16b. Kind of Business/Industry
<i>U.S. Navy Yard</i> | | | 17. Father's Name (First, Middle, Last)
<i>Orphus Miller</i> | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
<i>Clara Arnold</i> | | | 19a. Informant's Name/Relationship (Type, Print)
<i>Norma S. Miller (Wife)</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>114 Linden Avenue, Mayo, MD 21106</i> | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Maple Grove Cemetery</i> | | | 20c. Location - City or Town, State
<i>Boonville, Indiana</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Michelle P. Kutta</i> | | | 22. Name and Address of Facility
<i>Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401</i> | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Hepatorenal failure.</i>
Due to (or as a consequence of):
b. <i>s/p Abdominal Aortic Aneurysm repair.</i>
Due to (or as a consequence of):
c. <i>Pulmonary embolus</i>
Due to (or as a consequence of):
d. <i>Cardiogenic Shock</i> | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year)
<i>M</i> | | | 28b. Time of Injury
<i>1</i> Yes <input type="checkbox"/> No | | |
| 28c. Describe how injury occurred | | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>MD</i> | | | 29c. License number
<i>D0056208</i> | | | 29d. Date signed (Month, Day, Year)
<i>8/22/00</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Mark Decker MD 600 Ridgely Ave Suite 203 Annapolis MD 21401</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | | 32. Registrar's Signature
<i>Debra B. Sparks</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-8000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27034

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|---|---|--|---|--------------------------|--------|----------------------------------|--|-----------------|----------|----------------------------------|--|--|-------------------------|----------|----------------------------------|--|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jane Monroe | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
11:55am | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
The Johns Hopkins Hospital | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
220-64-6104 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | 8. Date of Birth (Month, Day, Year)
June 3, 1930 | 9. Birthplace (State or Foreign Country)
West Virginia | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
255 South Regester Street | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | | | | | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4+ College (1-4 or 5+) N/A | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
UNKNOWN | | 18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Michael Steven Monroe - Grandson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
255 South Regester Street Balto. Maryland 21231 | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery | | 20c. Location - City or Town, State
8-28-2000 Owings Mills, Maryland | | | | | | | | | | | | | | | | | |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
Charles J. Zannino | | 22. Name and Address of Facility
CHARLES S. ZANNINO LICENSED MORTICIAN
1915 ELLINWOOD ROAD BALTIMORE, MD 21237 | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial Infarction</td> <td>1 Hour</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Hypertension</td> <td>20 Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Hypercholesterolemia</td> <td>20 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table> | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 1 Hour | Due to (or as a consequence of): | | b. Hypertension | 20 Years | Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Hypercholesterolemia | 20 years | Due to (or as a consequence of): | | d. | | |
| | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 1 Hour | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| b. Hypertension | | 20 Years | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Hypercholesterolemia | 20 years | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Mark Richman MD | | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number
DO055767 | | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
August 23, 2000 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Richman, MD 600 N. WOLFE ST. BALTIMORE MD 21287 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
G. Sparks | | | | | | | | | | | | | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27035

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Teodoro Matiga | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
10:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
4602 Waterfall Court Apt E | | | | 4b. City, Town, or Location of Death
Owings Mills | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-27-1482 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 6, 1938 | |
| | 9. Birthplace (State or Foreign Country)
Philippines | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Owings Mills | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4602 Waterfall Court Apt E | | 10f. Zip Code
21117 | | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Asian | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 5 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanical Engineer | | 16b. Kind of Business/Industry
Medical | | |
| 17. Father's Name (First, Middle, Last)
Anatolio Matiga | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Narcisa Laoiao | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lilia Matiga Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4602 Waterfall Ct Apt E Owings Mills, MD 21117 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation Serv. | | 20c. Location - City or Town, State
8/25/00 Hampstead, Maryland | | 21. Signature of Funeral Service Licensee
Stephen M Jenkins | | |
| 22. Name and Address of Facility
Eline Funeral Home
11824 Reisterstown Road Reisterstown, MD 21136 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Adenocarcinoma of colon
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
5 years | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
Carl S. Friedman MD | | 29c. License number
020688 | | 29d. Date signed (Month, Day, Year)
8/24/2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carl S. Friedman MD, 515 Fairmount Ave. Towson, Md 21286 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
Benjamin Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27036

| | | | | | | | | |
|---|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FREDERICK J NORRIS | | | | 2. Date of Death
Month August Day 19 Year 2000 | | 3. Time of Death
7:28 AM | |
| | 4e. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-44-7384 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 24 1946 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Middle River | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
12734 Eastern Ave. | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (14 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Heavy Equipment Driver | | 16b. Kind of Business/Industry
Micky Smith Trucking | | | |
| | 17. Father's Name (First, Middle, Last)
John H. Norris | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Horn | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret Norris / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12734 Eastern Ave. Baltimore Md. 21220 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Cemetery | | 20c. Date
8/23/2000 | | 20d. Location - City or Town, State
Baltimore MD | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Arteriosclerotic Cardiovascular Disease 1 Year
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State
Registrar | 29b. Signature and Title of Certifier
[Signature] | | | | 29c. License number
D00 54725 | | 29d. Date signed (Month, Day, Year)
8/19/2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. J. Lopez 9000 Franklin Square Drive, Baltimore, Maryland. 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
[Signature] | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27037

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Mary Newgent</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>21</i> Year <i>2000</i> | | 3. Time of Death
<i>7:15 PM</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Howard County General Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Columbia</i> | | 4c. County of Death
<i>Howard</i> | | |
| Funeral
Director | 5. Social Security Number
<i>566-36-9706</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>70</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Nov. 21, 1929</i> | | |
| | 9. Birthplace (State or Foreign Country)
<i>Pennsylvania</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Edgewater</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>1048 Turkey Point Road</i> | | 10f. Zip Code
<i>21037</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>2</i> College (1-4or 5+) <i>2</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Computer Systems Analyst</i> | | 16b. Kind of Business/Industry
<i>Veterans Administration</i> | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>Stephen Strapac</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Catherine Yanski</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>James Newgent (Husband)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1048 Turkey Point Road, Edgewater, MD 21037</i> | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Metro Crematory</i> | | Date
<i>08/23</i>
<i>2000</i> | | 20c. Location - City or Town, State
<i>Baltimore, MD</i> | | | |
| 21. Signature of Funeral Service Licensee
<i>Michael P. Kutta</i> | | | | 22. Name and Address of Facility
<i>Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. METASTATIC Breast Cancer to the lungs</i>
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | Approximate Interval Between Onset and Death
<i>7 years</i> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
<i>M</i> | | 28b. Time of Injury
<i>1</i> Yes <input checked="" type="checkbox"/> No | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Nicholas L. Roudelakis MD</i> | | 29c. License number
<i>D38509</i> | | 29d. Date signed (Month, Day, Year)
<i>August 22 2000</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Nicholas L. Roudelakis 11065 Little Patuxent Pkwy Columbia MD 21044</i> | | 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | 32. Registrar's Signature
<i>Bernice B. Sparks</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27038

| | | | | | | | | | | |
|---|--|---|--|---|--|---------------------------------|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Russell Neumann | | | | 2. Date of Death
Month August Day 18 Year 2000 | | | | 3. Time of Death
6:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
399-12-7119 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 21, 1925 | | 9. Birthplace (State or Foreign Country)
Wisconsin | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
2525 W. Belvedere Avenue | | | | 10f. Zip Code
21215 | | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waiter | | | | 16b. Kind of Business/Industry
Restaurant | | |
| 17. Father's Name (First, Middle, Last)
UNK. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
UNK. | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Bernard Walstrum/Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Dublin Drive Lutherville, MD 21093 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | | | 20c. Location - City or Town, State
8-22-00 Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Tom Gregor | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc. | | | | 22. Address of Facility
299 Frederick Road Baltimore, MD 21228 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | a. Sepsis
Due to (or as a consequence of):
b. Urinary Tract Infection
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
10 days
14 days | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Beuminto MD | | | | 29c. License number
RES 000 | | |
| | | | | 29d. Date signed (Month, Day, Year)
August 18, 2000 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
B. Acosta MD - Sinai Hospital of Baltimore, Maryland | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
Sparks | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified in

ORIGINAL

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PAUL B. ODELL

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27, 28A-B PER MEO 6787 9-7-00 WR

Certificate of Death

Reg. No.

00 27039

Baltimore, Maryland 21215-0020

causal. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Paul Barclay Odell II | | | | 2. Date of Death
Month AUG. Day 23 Year 2000 | | 3. Time of Death
9:14 AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
213-44-8625 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 3, 1947 | | 9. Birthplace (State or Foreign Country)
Baltimore, Md. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Reisterstown | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
228 Highmeadow Rd. | | | | 10f. Zip Code
21136 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) +2 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Racing Official | | | 16b. Kind of Business/Industry
Maryland Race Track | |
| 17. Father's Name (First, Middle, Last)
Barclay Chapman Odell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anita Perkins Logsdon | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanne Odell - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
228 Highmeadow Rd. Reisterstown, Md. 21136 | | | | |
| 20e. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
Aug. 26, 2000 | | 20c. Location - City or Town, State
Baltimore, Md. |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
11605 Reisterstown Rd. Owings Mills, Md. 21117 | | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTIPLE SCLEROSIS | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 5. Pending investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> | | 28a. Date of Injury (Month, Day, Year)
8-23-00 | | 28b. Time of Injury
8:16 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
TIMONIUM | | 28d. Describe how injury occurred
DRIVER STRUCK BY A FIXED OBJECT | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2200 YORK RD. BALTIMORE COUNTY, MD | | | | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUG. 24, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
 | | | | |

11-11-61

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11-11-61

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27040

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Annie Mae Pryor</i> | | | | 2. Date of Death
Month <i>Aug.</i> Day <i>19</i> Year <i>2000</i> | | 3. Time of Death
<i>8:45 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>2224 W. LEXINGTON STREET</i> | | | | 4b. City, Town, or Location of Death
<i>BALTIMORE</i> | | 4c. County of Death
<i>N/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>214-22-8089</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>81</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>JUNE 29, 1919</i> | | 9. Birthplace (State or Foreign Country)
<i>VIRGINIA</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>2224 W. LEXINGTON STREET</i> | | | | 10f. Zip Code
<i>21223</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Housekeeping</i> | | 16b. Kind of Business/Industry
<i>St Agnes Hospital</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Henry Mason</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Sallie Morgan</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Linda Pryor / Daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3615 Raymond Ave Baltimore, Md 21213</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>KING Memorial Park</i> | | Date
<i>8/24/2000</i> | | 20c. Location - City or Town, State
<i>Woodlawn, Maryland</i> |
| 21. Signature of Funeral Service Licensee
<i>Jerry Harris</i> | | | | 22. Name and Address of Facility
<i>CHATHAM - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MARYLAND 21215</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
<i>a. Metastatic Endometrial Cancer</i>
<i>b. Renal Failure</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death

<i>9 months</i>
<i>2 years</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Suzanne M. Colter MD</i> | | | | 29c. License number
<i>D54995</i> | | 29d. Date signed (Month, Day, Year)
<i>August 21, 2000</i> | | |
| 30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
<i>601 N. Caroline Street Baltimore, MD 21029 Suzanne M Colter MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 25 2000</i> | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27041

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|---------------------|--|---------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY D PORTER | | | | 2. Date of Death
Month Day Year
AUGUST 22 2000 | | 3. Time of Death
10:30am | |
| | 4a. Facility Name (If not institution, give street and number)
1000 FRANKLIN AVE APT 806 | | | | 4b. City, Town, or Location of Death
ESSEX | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-05-0244 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 15 1921 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1000 Franklin Ave. Apt. 806 | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cafeteria Worker | | 16b. Kind of Business/Industry
Food Service | | 17. Father's Name (First, Middle, Last)
Thomas M Hickson | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Anna A Regler | | 19a. Informant's Name/Relationship (Type, Print)
Stephen B. Luers/son-in-law | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
51 Northwood Drive Timonium MD 21093 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Cemetery | | 20c. Date
8/25/2000 | | 20d. Location - City or Town, State
Baltimore MD | | 21. Signature of Funeral Service Licensee
R. Terry Connelly | |
| | 22. Name and Address of Facility
Connelly Funeral Home of Essex | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Atherosclerotic cardiovascular disease
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 23c. Approximate Interval Between Onset and Death | |
| | 23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
Sheldon Miller, MD | | 29c. License number
D18398 | | 29d. Date signed (Month, Day, Year)
08/22/00 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
404 Eastern Blvd (21221) | |
| 31. Date filed (Month, Day, Year)
AUG 23 2000 | | 32. Registrar's Signature
[Signature] | | 33. State Registrar | | 34. State Registrar | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27042

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARYLINDA PILLSBURY | | | | 2. Date of Death
Month AUGUST Day 22 Year 2000 | | 3. Time of Death
9:43am | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-40-3156 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 6 1942 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Randallstown | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
8339 Liberty Road | | 10f. Zip Code
21133 | | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | 16b. Kind of Business/Industry
Nursing | | |
| 17. Father's Name (First, Middle, Last)
Norman Folckemer | | | | 18. Mother's Name (First, Middle, Maiden Surname) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy Jackson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8309 Hartford Road Baltimore MD 21234 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | 20c. Date
8/24/2000 | | 20d. Location - City or Town, State
Baltimore MD. | | |
| 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cardiac arrhythmias
Due to (or as a consequence of):
Coronary artery disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
2-3 yrs | | Approximate Interval Between Onset and Death
5-10 mins | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Type II DM, HTN, Hyperlipidemia | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
M. H. MD | | 29c. License number
D-38754 | | 29d. Date signed (Month, Day, Year)
08-24-2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MALIKA WASEEM 709 EASTERN BLVD - MD - 21221 | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
[Signature] | | 33. Registrar's Name
[Signature] | | 34. Registrar's Title
[Signature] | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #1 per PHYG786 8/29/2000 EW

Certificate of Death

Reg. No.

00 27043

| | | | | | | | | |
|--|---|--|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Kalli Rose Curtis Pereira</u> | | | | 2. Date of Death
Month <u>8</u> Day <u>11</u> Year <u>2000</u> | | 3. Time of Death
<u>1750</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Laurel Regional Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Laurel</u> | | 4c. County of Death
<u>Prince Georges</u> | |
| Funeral
Director | 5. Social Security Number
<u>N/A</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. _____ | | 8. Date of Birth (Month, Day, Year)
<u>8/11/2000</u> | |
| | Usual Residence of Decedent | | 10a. State
<u>Md</u> | | 10b. County
<u>Howard</u> | | 10c. City, Town or Location
<u>Columbia</u> | |
| 10e. Street and Number
<u>6557 Quiet Hours Apt T-3</u> | | 10f. Zip Code
<u>21045</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>N/A</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>N/A</u> | | 16b. Kind of Business/Industry
<u>N/A</u> | | 17. Father's Name (First, Middle, Last)
<u>Corey Curtis</u> | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
<u>Dominique Pereira</u> | | 19e. Informant's Name/Relationship (Type, Print)
<u>Dominique Pereira - Mother</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6557 Quiet Hours Apt T-3 Columbia, Md 21045</u> | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Baltimore Washington Cr.</u> | | 20c. Location - City or Town, State
<u>Laurel, Maryland</u> | | 21. Signature of Funeral Service Licensee
<u>Thanda L Lemmer</u> M00741 | | 22. Name and Address of Facility
<u>Flect Funeral Home</u>
<u>7601 Sandy Spring Road Laurel, Md 20707</u> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. <u>Multiple Congenital Anomalies</u>
Due to (or as a consequence of): | | b. _____
Due to (or as a consequence of): | | c. _____
Due to (or as a consequence of): | | |
| d. _____ | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M _____ | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>Alice Tsai - MD</u> | | |
| 29c. License number
<u>D0053894</u> | | 29d. Date signed (Month, Day, Year)
<u>8/11/00</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Alice Tsai, Laurel Regional Hospital</u> | | 31. Date filed (Month, Day, Year)
<u>AUG 25 2000</u> | | |
| 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DAMIEN
RITCH

AMEND ITEMS: #23 PART I, 27 PER MFO G7878912-00 WR.

Certificate of Death

Reg. No.

00 27044

| | | | | | |
|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Damien Ritch | | 2. Date of Death
Month AUGUST Day 21 Year 2000 | | 3. Time of Death
9:59P.M. |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
213-92-4386 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
20 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
10-06-78 | | 9. Birthplace (State or Foreign Country)
MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
3109 Westmont Court | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade | | College (1-4 or 5+)
NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supply Clerk | |
| 16b. Kind of Business/Industry
Retirement Ctn | | Charlestown | | | |
| 17. Father's Name (First, Middle, Last)
Richard M.T. Ritch, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carolyn Daaney | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carolyn Ford | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213
1639 Darley Avenue Baltimore, Maryland | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. Cem. 08-28-2000 Randallstown, MD | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
Bladys Wane | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIAC ARRHYTHMIA ASSOCIATION WITH RIGHT VENTRICULAR HYPERTROPHY | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Joseph Pestaner, M.D. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 22, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
Benita B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Testament

Danney

James, Mary

Randall

Mary
A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27045

| | | | | | | | | |
|--|--|--|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ida Richardson | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
2:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner Health of Glen Burnie | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
218-20-4088 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 6, 1904 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
7355 E. Furnace Branch Road | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Herb Pierce | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Susan UNK. | | 19a. Informant's Name/Relationship (Type, Print)
Patricia LaMartina/Caregiver | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
219 Candlelight La. Glen Burnie, MD 21061 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | 20c. Date
8-24-00 | | 20d. Location - City or Town, State
Baltimore, MD | | 21. Signature of Funeral Service Licensee
Edward A. Gregorchik | | |
| 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ISCHEMIC CARDIOVASCULAR EVENT
Due to (or as a consequence of):

b. GENERALIZED ARTERIOSCLEROSIS
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
1 MINUTE
10 YEARS. | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- MONOCLONAL GAMMATHY
ANEMIA | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
L. Leidy | | 29c. License number
D-22609 | | |
| 29d. Data signed (Month, Day, Year)
AUGUST 23, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLENBURNIE MD 21060 | | 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Longwood

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27046

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--------------------------|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna Marie Rosier | | | | | | 2. Date of Death
Month Day Year
August 18, 2000 | | 3. Time of Death
5:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris | | | | | | 4b. City, Town, or Location of Death
Timonium | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
219-40-6242 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 11, 1910 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
2300 Dulaney Valley Road | | | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Real Estate Agent | | | 16b. Kind of Business/Industry
Real Estate | | | |
| 17. Father's Name (First, Middle, Last)
Anthony J. Haebler | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Brendel | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert Rosier/Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2021 Garden Drive Forest Hill, Maryland 21050 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer Cemetery | | | 20c. Date
8/21/00 | | 20d. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Dippel Funeral Home Inc.
6415 Belair Road Baltimore, Maryland 21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Atherosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of):
b. <u>Hypertension</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Chronic Obstructive Pulmonary Disease</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D53283 | | 29d. Date signed (Month, Day, Year)
8/18/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christophere ISK MD.
147 South Weaver St Baltimore MD 21230 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27047

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PHYLLIS SCHULTZ

2. Date of Death
Month Day Year

August 22 2000 825 pm

3. Time of Death

825 pm

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

RANDOLPH TOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

578-74-8978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

8. Date of Birth (Month, Day, Year)

May 27-1941

9. Birthplace (State or Foreign Country)

NEW YORK

10a. State

MD

10b. County

Balto.

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6212 Craigmont Rd.

10f. Zip Code

21228-1235

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teacher/ asst. principal

16b. Kind of Business/Industry

school system

17. Father's Name (First, Middle, Last)

William Kritzer

18. Mother's Name (First, Middle, Maiden Surname)

Edith Suplee

19a. Informant's Name/Relationship (Type, Print)

Ray Schultz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6212 Craigmont Rd. Baltimore, Md. 21228-1235

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

8/28/2000

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

Kim Schlaner

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
1630 Edmondson Ave., Catonsville, Md. 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

E.P. Williams MD

29c. License number

D11171

29d. Date signed (Month, Day, Year)

AUGUST 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.P. Williams MD 405 FREDERICK AVE CATONSVILLE 21228

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

Beverly B Sparks

MARYLAND

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CS
00-4705-011
DEBRA SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27048

AMEND ITEMS: #23 ART I, 27 PER MEO G 287,911-00 WR.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DEBRA MARIE SMITH | | | | 2. Date of Death
Month Day Year
AUGUST 18 2000 | | | | 3. Time of Death
4:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
209 SOUTH 8th STREET APARTMENT 608 | | | | 4b. City, Town, or Location of Death
DENTON | | | | 4c. County of Death
CAROLINE | |
| Funeral
Director | 5. Social Security Number
220-80-0394 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
41 Yrs. | | 8. Date of Birth (Month, Day, Year)
1/30/1959 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
CAROLINE | | 10c. City, Town or Location
DENTON | |
| To Be Completed by Funeral Director | | 10e. Street and Number
209 SOUTH 8TH STREET APARTMENT 608 | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
USA | | |
| | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
OFFICE ASSISTANT | | 16b. Kind of Business/Industry
STATE OF MARYLAND
DEPARTMENT OF HEALTH | | | | |
| | | 17. Father's Name (First, Middle, Last)
JAMES H. SMITH, SR. | | 18. Mother's Name (First, Middle, Maiden Surname)
DELMA CHARLTON | | | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print)
JAMES H. SMITH, SR., / FATHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
305 W 11TH AVE., BALTIMORE, MD 21225 | | | | | | |
| | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROSEDALE CEMETERY | | 20c. Location - City or Town, State
8/23/00 MARTINSBURG, WV | | | | |
| | | 21. Signature of Funeral Service Licensee
Charles M. Brown | | 22. Name and Address of Facility
BROWN FUNERAL HOME, 327 W. KING ST.,
PO BOX 821, MARTINSBURG, WV 25402 | | | | | | |
| | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIAC ARRHYTHMIA IN ASSOCIATION WITH
HYPERTENSIVE CARDIOVASCULAR DISEASE AND
OBESITY | | Approximate Interval Between Onset and Death | | | | | | |
| Physician
/Medical
Examiner | | Immediate Cause (Final disease or condition resulting in death)
Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | |
| | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | Due to (or as a consequence of): | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | 24e. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Margaret Melville M.D. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 19, 2000 | | |
| State Registrar | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
H. KORON 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| | | 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
B. Spauld | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27049

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Claude Henry Speight | | | | | | 2. Date of Death
Month August Day 22 Year 2000 | | 3. Time of Death
11 45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Augsburg Lutheran Home | | | | | | 4b. City, Town, or Location of Death
Lochearn | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
217-18-3084 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
95 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 16, 1904 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | 10a. State
Maryland | | | | | | 10b. County
Baltimore | | 10c. City, Town or Location
Lochearn | |
| 10e. Street and Number
6811 Campfield Road | | | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
10th. Grade | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed | | | 16b. Kind of Business/Industry
Grocery Store | |
| 17. Father's Name (First, Middle, Last)
James Nathaniel Speight, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Lee Nash | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Beverly Speight-Mohamed/ Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
37 Oak Hills Dr Hanover PA 17331 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | 20c. Location - City or Town, State
8/26/2000 Baltimore MD | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | | 22. Name and Address of Facility
John C. Miller, Inc
6415 Belair Road Baltimore MD 21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
years | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | |
| | | | | | | 29c. License number
D15872 | | 29d. Date signed (Month, Day, Year)
August 23 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harold BUB MD 25 Main St Reisterstown md 21136 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27050

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY W. TACKA | | | | 2. Date of Death
Month Day Year
AUGUST 23 2000 | | 3. Time of Death
6:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital 900 Caton Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-40-1507 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
12-4-1942 | | 9. Birthplace (State or Foreign Country)
MD. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
115 Smithwood Ave. | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | 16b. Kind of Business/Industry
home | | |
| 17. Father's Name (First, Middle, Last)
Walton Sandoz | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Sandoz | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Thomas Tacka, Jr. - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Smithwood Ave., Catonsville, Md. 21228 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore/ Washington Cre | | 20c. Location - City or Town, State
8/28/2000 Laurel, Md. | | |
| 21. Signature of Funeral Service Licensee

MC0192 | | | | 22. Name and Address of Facility
Witzke Funeral Home, Inc.
1630 Edmondson Ave., Catonsville, MD. 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Small Cell Carcinoma of the lung | | | | | | | | 10 months |
| Due to (or as a consequence of): | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Tobacco Use | | | | | | | | 25 years |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier

George Drost, M.D. | | | | 29c. License number
P14442 | | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Drost, M.D. 900 Caton Avenue, Baltimore, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature

Sparks | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

NAME Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27051

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rita Trapani | | | | 2. Date of Death
Month Day Year
August 24 2000 | | 3. Time of Death
6:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner North Arundel | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
072-01-9071 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
AUGUST 28 1914 | | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
146 Kentucky Avenue | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Manager | | | 16b. Kind of Business/Industry
Dental Office | |
| 17. Father's Name (First, Middle, Last)
Frank Deo Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna E. Joell | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Oakley(daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
146 Kentucky Ave., Pasadena, MD. 21122 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, INC. | | Date
Aug. 28 2000 | | 20c. Location - City or Town, State
Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Stallings Funeral Home, P.A.
3111 Mountain Rd., Pasadena, MD. 21122 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
a. Cardiorespiratory failure
b. Coronary artery disease
c. Atherosclerotic arterial disease
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
HOURS
YEARS
YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ANEMIA, GASTROESOPHAGEAL REFLUX
PREVIOUS MYOCARDIAL INFARCTION, CHRONIC
ATRIAL FIBRILLATION, BREAST MASS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] MD | | | | 29c. License number
D54288 | | 29d. Date signed (Month, Day, Year)
AUGUST 24 TH 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMASHAMY I RANGARAJAN 7445 FURNACE BRANCH RD GLEN BURNIE MD 21060 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | 32. Registrar's Signature
[Signature] | | | | |

ORIGINAL

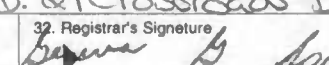
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27052

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|------------------------------|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Irvin Andrew Wilhelm | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
3:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
4230 2D Crystal Ct. | | | | 4b. City, Town, or Location of Death
Hampstead | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
220-24-1700 | | 6. Sex
100 M 200 F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 7, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Upperco, Md. | | 10a. State
Md. | | 10b. County
Carroll | | 10c. City, Town or Location
Hampstead | |
| 10d. Inside City Limits
100 Yes 200 No | | 10e. Street and Number
4230 2D Crystal Ct. | | 10f. Zip Code
21074 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
100 Never Married 200 Married 300 Widowed 400 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
100 Yes 200 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
100 Yes 200 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) +2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Management Dept. | | 16b. Kind of Business/Industry
Black & Decker | | 17. Father's Name (First, Middle, Last)
Irvin Gilbert Wilhelm | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Amanda Khoten | | 19a. Informant's Name/Relationship (Type, Print)
Marianna W. Wilhelm - wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4230 2D Crystal Ct. Hampstead, Md. 21074 | | 20a. Method of Disposition
100 Burial 200 Cremation 300 Removal from State 400 Donation 500 Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Taylorville Cem. | | 20c. Date
Aug. 28, 2000 | | 20d. Location - City or Town, State
Taylorville, Md. | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Eckhardt Funeral Chapel | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
METASTATIC ANAC CA | | 23b. Approximate Interval Between Onset and Death
3 yrs | | 23c. Did tobacco use contribute to the cause of death?
100 Yes 200 No 300 Probably 400 Unknown | | |
| 24a. Was an autopsy performed?
100 Yes 200 No | | 24b. Were autopsy findings available prior to completion of cause of death?
100 Yes 200 No | | 25. Was case referred to medical examiner?
100 Yes 200 No | | 26. Place of Death (Check only one)
Hospital: 100 Inpatient 200 ER/Outpatient 300 DOA Other: 400 Nursing Home 500 Residence 600 Other (Specify) | | |
| 27. Manner of Death
100 Natural 200 Accident 300 Suicide 400 Homicide 500 Pending Investigation 600 Could not be determined | | 28a. Date of Injury (Month, Day, Year)
M | | 28b. Time of Injury
M | | 28c. Injury at Work?
100 Yes 200 No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 200 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
 MD | | 29c. License number
D35398 | | 29d. Date signed (Month, Day, Year)
8-25-00 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Flavio Kruter, M.D. 21 Crossroads Drive Suite 415 Owings Mills MD 21117. | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
 | | 33. State Registrar
State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

ORIGINAL

From the [illegible]

Went to [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27053

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|---------------------------------|--------------------------------|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALVIN BLACK | | | | 2. Date of Death
Month AUGUST Day 4 Year 2000 | | | | 3. Time of Death
09:43 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death | | | | |
| Funeral
Director | 5. Social Security Number
205-12-2670 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | If Under 1 Year
Months Days | | 8. Date of Birth (Month, Day, Year)
May 31, 1923 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | | | 10b. County
Worcester | | 10c. City, Town or Location
Berlin | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
80 Sandyhook Road | | | | 10f. Zip Code
21811 | | | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: 1943-1963 | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electronics Engineer | | | | 16b. Kind of Business/Industry
AAI Corp | | | | | |
| 17. Father's Name (First, Middle, Last)
Lawrence Wilson Black | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Elizabeth Hulton | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Melba Faye Black, wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
80 Sandyhook Road, Berlin, MD 21811 | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremations | | | | Date
8/5 | | 20c. Location - City or Town, State
Hampstead, MD | | | |
| 21. Signature of Funeral Service Licensee
Steuwage M00723 | | | | 22. Name and Address of Facility
Eline Funeral Home
934 South Main St, Hampstead, MD 21074 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cerebrovascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Air Embolism

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Aspiration Pneumonia | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Christopher Lutcavage | | | | 29c. License number
AU417643SL2444 | | 29d. Date signed (Month, Day, Year)
AUGUST 4 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
University of Maryland Hospital, Baltimore Maryland 21201 | | | | 31. Date filed (Month, Day, Year)
AUG 09 2000 | | | | 32. Registrar's Signature
Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27054

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|--|--|--------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Norburt Bull</i> | | 2. Date of Death
Month <i>Aug</i> Day <i>6</i> Year <i>2000</i> | | 3. Time of Death
<i>10:59a.m.</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>Howard County General Hospital</i> | | 4b. City, Town, or Location of Death
<i>Columbia</i> | | 4c. County of Death
<i>Howard</i> |
| Funeral
Director | 5. Social Security Number
<i>212-26-5814</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>71</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<i>Dec 29, 1928</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Reisterstown</i> | |
| 10e. Street and Number
<i>11917 Tarragon Rd</i> | | 10f. Zip Code
<i>21136</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Truck Driver</i> | | 16b. Kind of Business/Industry
<i>Trucking</i> | |
| 17. Father's Name (First, Middle, Last)
<i>Melvin Bull</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Mildred Cox</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Donald Shauck, friend</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1744 Baltimore Blvd, Westminster, MD 21157</i> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Evergreen Memorial Park</i> | | 20c. Location - City or Town, State
<i>8/10 Finksburg, MD</i> | |
| 21. Signature of Funeral Service Licensee
<i>Steve W. Elene</i> M00723 | | 22. Name and Address of Facility
<i>Eline Funeral Home</i>
<i>934 South Main St, Hampstead, MD 21074</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

<i>a. meningioma</i>
Due to (or as a consequence of):

<i>b.</i>
Due to (or as a consequence of):

<i>c.</i>
Due to (or as a consequence of):

<i>d.</i> | | Approximate Interval Between Onset and Death
<i>6 months</i> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Respiratory failure</i> | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Gary Kazlow MD</i> | | 29c. License number
<i>D00041617</i> | |
| 29d. Date signed (Month, Day, Year)
<i>August 6, 2000</i> | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Gary Kazlow, M.D., 10805 Hickory Ridge Rd., Columbia, MD 21044</i> | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 09 2000</i> | | 32. Registrar's Signature
<i>Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27055

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pauline Mary Bowers | | | | 2. Date of Death
Month August Day 8 Year 2000 | | | | 3. Time of Death
7:20AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Glade Valley Nursing & Rehabilitation Ctr. | | | | 4b. City, Town, or Location of Death
Walkersville | | | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
216-10-6161 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 13, 1915 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Taneytown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2175 Trevanion Rd. | | | | 10f. Zip Code
21787 | | | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
factory worker | | | | 16b. Kind of Business/Industry
rubber co. | | |
| | 17. Father's Name (First, Middle, Last)
Elmer Crumbacker | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Glenna Stauffer | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Richard E. Frounfelter/ son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1528 Miller Rd. Westminster, MD 21158 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Lutheran Cem. | | Date
8/11/00 | | 20c. Location - City or Town, State
Uniontown, MD | | | | |
| | 21. Signature of Funeral Service Licensee
Catharine O. Hartzler | | | | 22. Name and Address of Facility
Hartzler Funeral Home
310 Church St. New Windsor, MD 21776 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.
Immediate Cause (Final disease or condition resulting in death)
Congestive Heart Failure
Due to (or as a consequence of):
Atherosclerotic Cardiovascular Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dementia | | | | | | | | Approximate Interval Between Onset and Death
years
years | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Aunt | | | | 29c. License number
D26576 | | 29d. Date signed (Month, Day, Year)
August 10 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Allen J. Wilson MD 1475 TANB7 Ave FRED MD 21702 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
B Sparks | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27056

| | | | | | | | | | | | | |
|---|---|---|---|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAUREEN ROSE BROTHERS | | | | | 2. Date of Death
Month Day Year
AUG. 11, 2000 | | 3. Time of Death
3:30 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
3053 SHOOTING STAR DR. | | | | | 4b. City, Town, or Location of Death
FINKSBURG | | 4c. County of Death
CARROLL | | | | |
| Funeral
Director | 5. Social Security Number
213-62-0593 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
6/28/1955 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
CARROLL | | 10c. City, Town or Location
FINKSBURG | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
3053 SHOOTING STAR DR. | | | | 10f. Zip Code
21048 | | 10g. Citizen of What Country?
USA. | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FAMILY SERVICE SPECIALIST | | | | 16b. Kind of Business/Industry
SCHOOL | | | | |
| | 17. Father's Name (First, Middle, Last)
VINCENT JAMES FIORE | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY PATRICIA HAGARTY | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
TERRY L. BROTHERS -HUSBAND | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3053 SHOOTING STAR DR., FINKSBURG, MD. 21048 | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVERGREEN MEM. GARDENS | | Date
8/14/00 | | 20c. Location - City or Town, State
FINKSBURG, MD. | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. METASTATIC COLON CA
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| State Registrar | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier

Flavio Kruter MD | | | | | 29c. License number
D35398 | | 29d. Date signed (Month, Day, Year)
8-14-00 | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Flavio Kruter, M.D. 224 Washington Heights Medical Center, Westminster, MD 21157 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
 | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 17, per F.D. State of Maryland / Department of Health and Mental Hygiene
08/14/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 27057

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | | 1. Decedent's Name (First, Middle, Last)
<u>Mildred Louise Bowman</u> | | | | 2. Date of Death
Month <u>8</u> Day <u>9</u> Year <u>00</u> | | 3. Time of Death
<u>8 58 pm</u> | | | |
| Funeral Director | | 4a. Facility Name (If not institution, give street and number)
<u>CCGH - Carroll County General Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Westminster</u> | | 4c. County of Death
<u>Carroll</u> | | | |
| 5. Social Security Number
<u>213647166</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>88</u> Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | | |
| 8. Date of Birth (Month, Day, Year)
<u>Jul 21, 1912</u> | | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
<u>MD</u> | | 10b. County
<u>Carroll</u> | | 10c. City, Town or Location
<u>Westminster</u> | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
<u>325 Robins Way</u> | | | | 10f. Zip Code
<u>21158</u> | | 10g. Citizen of What Country?
<u>USA</u> | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>8</u> College (14 or 5+) _____ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Housewife</u> | | | 16b. Kind of Business/Industry
<u>Own Home</u> | | | | |
| 17. Father's Name (First, Middle, Last)
<u>Harry Peltzer</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Susie Hatton</u> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Douglas Bowman, son</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>325 Robins Way Apt 2D, Westminster, Md 21158</u> | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Wesley Cemetery</u> | | Date
<u>8/12</u> | | 20c. Location - City or Town, State
<u>Hampstead, MD</u> | | | | | |
| 21. Signature of Funeral Service Licensee
<u>Steve Eline</u> M00723 | | | | 22. Name and Address of Facility
<u>Eline Funeral Home</u>
<u>934 South Main St, Hampstead, MD 21074</u> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>Asystole</u>
Due to (or as a consequence of):

b. <u>Acute myocardial infarction</u>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>Hamling House staff</u> | | | | 29c. License number
<u>D 51596</u> | | 29d. Date signed (Month, Day, Year)
<u>August 9th 2000</u> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>K. Ambalavanar, Carroll County General Hospital, 200, Memorial Ave Westminster MD 21157</u> | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
<u>AUG 14 2000</u> | | 32. Registrar's Signature
<u>Benita B Sparks</u> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27058

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bobby Keith Breeding

2. Date of Death

Month

Day

Year

August 11 2000

3. Time of Death

4:08 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

226-38-0035

6. Sex

M 20 F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 10, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

717 Glen Drive

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sheetmetal Worker

16b. Kind of Business/Industry

Kaiser Aluminum

17. Father's Name (First, Middle, Last)

Frank Breeding

18. Mother's Name (First, Middle, Maiden Surname)

Rose Stintson

19a. Informant's Name/Relationship (Type, Print)

Bonnie Breeding (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

717 Glen Dr. Westminster, MD 21157

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadow Branch Cem.

Date

8-14 Westminster, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel, P.A.

412 Washington Rd. Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending Investigation

20 Accident

30 Suicide

40 Homicide

60 Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

10 Certifying Physician:

20 Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alden G. Peoples, MD

29c. License number

D0050693

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alden G. Peoples 2401 W. Belvedere Ave, Baltimore, MD 21215

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Alden G. Peoples

ORIGINAL

Bobby Breeding

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27059

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Richard Corbin

2. Date of Death

8/11/00

3. Time of Death

5A

4a. Facility Name (If not institution, give street and number)

3035 Langdon Drive

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

219-12-1160

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 2, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3035 Langdon Drive

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Dry Cleaning

17. Father's Name (First, Middle, Last)

John E. Corbin

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Lingg

19a. Informant's Name/Relationship (Type, Print)

Elisabeth C. Corbin/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3035 Langdon Dr, Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Uniontown Church of God Cemetery

Date

8/14

20c. Location - City or Town, State

Uniontown, Maryland

21. Signature of Funeral Service Licensee

Robert A. Myers

22. Name and Address of Facility

Myers Funeral Home

91 Willis Street
Westminster, MD 2115723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Dementia

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 mo.

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28e. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John F. Smith

29c. License number

D20380

29d. Date signed (Month, Day, Year)

8/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Smith, 104 N. Main St., Union Bridge, MD 21791

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Jenna B. Sparks

JOHN RICHARD CORBIN
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27060

| | | | | | | | | | | |
|--|--|------------------------|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen Doris Cramer | | | | | | 2. Date of Death
Month Day Year
August 10 2000 | | 3. Time of Death
12:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Long View Nursing Home | | | | | | 4b. City, Town, or Location of Death
Manchester | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
219-20-4010 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 29, 1913 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
New Windsor | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
124 Church St. | | | | 10f. Zip Code
21776 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
seamstress | | | 16b. Kind of Business/Industry
clothing factory | | | |
| 17. Father's Name (First, Middle, Last)
Walter L. Weller Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Alverta Gutman | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edna M. Rickrode - daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
945 Impounding Dam Rd., Hanover, PA 17331 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. | | Date
Aug 11 2000 | | 20c. Location - City or Town, State
Hampstead, MD | | |
| 21. Signature of Funeral Service Licensee
<i>Catherine Q. Hartzler</i> | | | | 22. Name and Address of Facility
Hartzler Funeral Home
310 Church St., New Windsor, MD | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. <i>Urogenital disease</i>
Due to (or as a consequence of): | | | | | | | | | | 15y |
| b. <i>Sepsis</i>
Due to (or as a consequence of): | | | | | | | | | | 2 wk |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>John W. Middelton</i> | | | | | | 29c. License number
D25443 | | 29d. Date signed (Month, Day, Year)
8-11-2000 | | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
<i>John W. Middelton 688 Park Rd, Westminster, Md 21157</i> | | | | | | | | | | |
| 31. Date (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27061

| | | | | | | | | | | | |
|--|---|------------------------------|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Evelyne Martha Hudgins Hurt | | | | | | 2. Date of Death
Month August Day 7 , Year 2000 | | 3. Time of Death
2:07pm | | |
| | 4a. Facility Name (If not institution, give street and number)
WILLIAM HILL MANOR | | | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | | |
| Funeral
Director | 5. Social Security Number
215-16-4106 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 19, 1913 | | 9. Birthplace (State or Foreign Country)
VA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
501 DUTCHMANS LANE | | | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | | |
| 17. Father's Name (First, Middle, Last)
ROYAL LAMBERT HUDGINS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JETTY LOU PAGE | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOHN W. HURT, JR/ SON | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 LONDONDERRY DR., EASTON, MD 21601 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING HILL CEMETERY | | Data
8-11-00 | | 20c. Location - City or Town, State
EASTON, MD | | | |
| 21. Signature of Funeral Service Licensee
JOHN R. MERCERON | | | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA
200 S. HARRISON ST, EASTON, MD 21601 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Respiratory failure
Due to (or as a consequence of):
acute exacerbation of chronic obstructive lung disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
MD | | | | 29c. License number
DZ5750 | | 29d. Date signed (Month, Day, Year)
8-7-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE, EASTON, MD 21601 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 09 2000 | | | | 32. Registrar's Signature
B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 27062

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE ALYOUSIS HICKS | | | | 2. Date of Death
Month AUGUST Day 11 , Year 2000 | | 3. Time of Death
10:48 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
CIVISTA MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
LAPLATA | | 4c. County of Death
CHARLES | | |
| Funeral
Director | 5. Social Security Number
217-60-9407 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 25, 1952 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Charles | | 10c. City, Town or Location
Newburg | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
9799 Emerald Lane | | 10f. Zip Code
20664 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Cable Company | | | | | |
| 17. Father's Name (First, Middle, Last)
Harry Theodore Hicks, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Ada Scramble Hopewell | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara Ann Hicks/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 1895 La Plata, Md. 20646 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Cemetery | | Date
8/19/00 | | 20c. Location - City or Town, State
La Plata, MD. | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
M00945 AREHART-ECHOLS FUNERAL HOME, P.A.
P.O. BOX 567 La Plata, MD 20646 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. STAB Wound of CHEST
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. Date of injury (Month, Day, Year)
8/11/00 | | 28b. Time of injury (EST)
9:55P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 28d. Describe how injury occurred
SUBJECT STABBED | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
9799 EMERALD LANE
NEWBURG, MD | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 12, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TIRUS, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27063

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CYNTHIA MARIE HASTINGS

2. Date of Death

Month Year
AUGUST 11 2000

3. Time of Death

12:00PM

4a. Facility Name (If not institution, give street and number)

5260 WESLEY ROAD

4b. City, Town, or Location of Death

RHODESDALE

4c. County of Death

DORCHESTER

Funeral
Director

5. Social Security Number

216-80-7503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 5, 1958

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

RHODESDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5260 WESLEY ROAD

10f. Zip Code

21659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CEO/OWNER

16b. Kind of Business/Industry

CONSTRUCTION COMPANY

17. Father's Name (First, Middle, Last)

CHARLES TYSON HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

GRACE LOUISE HECK

19a. Informant's Name/Relationship (Type, Print)

ROBERT R. HASTINGS/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5260 WESLEY ROAD, RHODESDALE, MARYLAND 21659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ELDORADO CEMETERY

Date

8/14/00

20c. Location - City or Town, State

ELDORADO, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207
106 MAIN STREET, EAST NEW MARRKET, MD 2163123. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Non-small cell carcinoma of lung; metastatic
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0054812

29d. Date signed (Month, Day, Year)

8/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kimberlie A. Neal MD; 3304 Hayman Drive, Federalburg, MD 21632

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

State
RegistrarBaltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

1000

1000

00 27064

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27065

| | | | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Hicks Lawing | | | | 2. Date of Death
Month Day Year
August 7, 2000 | | 3. Time of Death
2:50am | | |
| | 4a. Facility Name (If not institution, give street and number)
WILLIAM HILL MANOR | | | | 4b. City, Town, or Location of Death
EASTON | | 4c. County of Death
TALBOT | | |
| Funeral
Director | 5. Social Security Number
244-07-0625 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
MARCH 26, 1909 | | |
| | 9. Birthplace (State or Foreign Country)
N.C. | | 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
EASTON | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
501 DUTCHMANS LANE APT 323 | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) 2 | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
COSMETOLOGIST | | 16b. Kind of Business/Industry
BEAUTY SALON | | 17. Father's Name (First, Middle, Last)
CHARLES A. HICKS | | 18. Mother's Name (First, Middle, Maiden Surname)
JANOLA KELLAR | | 19. Informant's Name/Relationship (Type, Print)
ALVIN L. LAWING/ SON | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
218 S. HARRISON ST., EASTON, MD 21601 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION CTR | | 20c. Date
8-7-00 | | 20d. Location - City or Town, State
STEVENSVILLE, MD | |
| 21. Signature of Funeral Service Licensee
<i>Man E. Thompson</i> & CFSP | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, PA
200 S. HARRISON ST, EASTON, MD 21601 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. acute cerebrovascular event
Due to (or as a consequence of):
b. atherosclerotic cardiovascular disease years
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 hr. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Robert B. Sanchez</i> MD | | 29c. License number
D25750 | | 29d. Date signed (Month, Day, Year)
8-7-00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT B. SANCHEZ M.D. 503 IDLEWILD AVE, EASTON, MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 07 2000 | | 32. Registrar's Signature
<i>R. Sparks</i> | | | | | | | |

586. Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

246554

10. 1942

17. 1942

18. 1942

19. 1942

20. 1942

21. 1942

22. 1942

23. 1942

24. 1942

25. 1942

26. 1942

27. 1942

28. 1942

29. 1942

30. 1942

31. 1942

32. 1942

33. 1942

34. 1942

35. 1942

36. 1942

37. 1942

38. 1942

39. 1942

40. 1942

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27066

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|------------------|----------------------------------|---|--|------------------------------------|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDGAR THOMAS LOGUE | | | | 2. Date of Death
Month Day Year
August 10 2000 | | 3. Time of Death
07:45 PM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Carroll County General Hospital | | | | 4b. City, Town, or Location of Death
Westminster | | 4c. County of Death
Carroll county | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-20-3216 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug 25, 1928 | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
New Windsor | | | | | | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1318 Dennings Rd. | | 10f. Zip Code
21776 | | | | | | | | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Butcher | | 16b. Kind of Business/Industry
William F. Myers | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Edgar Upton Logue | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Harriet Jones Myers | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Shirley Irene Logue - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1318 Dennings Rd. New Windsor, MD 21776 | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Locust Grove Cemetery | | 20c. Date
8/14/00 | | 20d. Location - City or Town, State
Mount Airy, Maryland | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility Burrier-Queen Funeral Directors
1212 West Old Liberty Rd. Winfield, MD 21784 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. sepsis</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death
days</td> </tr> <tr> <td>b. end-stage lung disease with pulmonary fibrosis</td> </tr> <tr> <td>c. congestive heart failure</td> </tr> <tr> <td>d. </td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
days | b. end-stage lung disease with pulmonary fibrosis | c. congestive heart failure | d. |
| Immediate Cause (Final disease or condition resulting in death) | a. sepsis | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
days | | | | | | | | | | | |
| | b. end-stage lung disease with pulmonary fibrosis | | | | | | | | | | | | | |
| | c. congestive heart failure | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Hwan Y. Yoo, M.D. | | | | 29c. License number
D0053514 | | 29d. Date signed (Month, Day, Year)
August 10 2000 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hwan Y. Yoo, M.D. Carroll County General Hospital 200 Memorial Ave. Westminster, MD 21157 | | | | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
AUG 11 2000 | | 32. Registrar's Signature
 | | | | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Edgar Logue

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27067

Amendment item#4a & 10e, QACHD, 7/17/00, tw Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Ruth Lyman Mider

2. Date of Death
Month Day Year
July 14 2000

3. Time of Death
2:30am

4a. Facility Name (If not Institution, give street and number)

108 Bryan's Channel Road Way

4b. City, Town, or Location of Death

Queenstown

4c. County of Death

Queen Anne's

5. Social Security Number

215-44-4030

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 16 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Queenstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 Bryan's Channel Road Way

10f. Zip Code

21658

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Practitioner

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Charles A. Lyman

18. Mother's Name (First, Middle, Maiden Surname)

Ada Boyd

19a. Informant's Name/Relationship (Type, Print)

Ruth M. Maynard / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Bryans Channel Way Queenstown, MD. 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center

Date

7/15/00

20c. Location - City or Town, State

Stevensville, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.
106 Shamrock Road Chester, MD. 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUBDURAL HEMATOMA

WEEKS

Due to (or as a consequence of):

CHRONIC ANTICOAGULATION

YEARS

Due to (or as a consequence of):

CVA

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D38457

29d. Date signed (Month, Day, Year)

JULY 14, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

N. GONALVES, 3801 INTERNATIONAL DR, SILVER SPRING MD 20906

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27068

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NANCY MAXWELL MATTHEW

2. Date of Death

Month Day Year
AUGUST 13, 2000

3. Time of Death

4:00AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GLASGOW NURSING HOME

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

5. Social Security Number

219-36-5382

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 17, 1901

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

HURLOCK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4212 OSBORNE ROAD

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

STEWART MAXWELL

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

JANET O. EWING/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4272 OSBORNE ROAD, HURLOCK, MARYLAND 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EAST NEW MARKET CEMETERY

Date

8/14/00

20c. Location - City or Town, State

EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207

106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart-Disease

Due to (or as a consequence of):

b. Congestive Heart-Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D 47924

29d. Date signed (Month, Day, Year)

8-15-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORMAN THAWNY 300 AURORA STREET CAMBRIDGE MD 21613

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

ORIGINAL

NANCY MAXWELL MATTHEW 8/13/2000 4AM

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020 Ldb
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

James L. Smith

Aug 18 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27069

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|-------------------------------|---|--|--|---|---------|---|---------------------------|--|--|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|--|--|---|-----------------|--|--|--|--|--|--|--|---------|----------------------------------|--|--|--|--|--|--|--|--|-------------|--|--|--|--|--|--|--|-------|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gretchen Eleanor Nahrwold | | | | | | 2. Date of Death
Month Day Year
August 9 2000 | | 3. Time of Death
8:20 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
3224 Mellenbrook Road | | | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
314-01-2459 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 2, 1913 | | 9. Birthplace (State or Foreign Country)
Indiana | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
6203 Oak Hill Drive | | | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Postal Employee | | | 16b. Kind of Business/Industry
U.S. Government | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Louis Fuelling | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Christ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jackie N. Taylor/Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6203 Oak Hill Drive Sykesville, Maryland 21784 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. | | 20c. Date
8/10/2000 | | 20d. Location - City or Town, State
Hampstead, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Jeffrey N. Zimbrun | | | | | | 22. Name and Address of Facility
Jeffrey N. Zimbrun F.H.
6028 Sykesville Road Eldersburg, Maryland 21784 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Physician
/Medical
Examiner | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">a. STROKE - MULTI INFARCT</td> <td>Approximate Interval Between Onset and Death
years</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="8">b. Hypertension</td> <td>Unknown</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">c. Dementia</td> <td>years</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="10">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
aspirin pneumonia
virus heart infection</td> </tr> <tr> <td colspan="10">23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="5">24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="5">24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. STROKE - MULTI INFARCT | | | | | | | | Approximate Interval Between Onset and Death
years | Due to (or as a consequence of): | | | | | | | | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Hypertension | | | | | | | | Unknown | Due to (or as a consequence of): | | | | | | | | | c. Dementia | | | | | | | | years | Due to (or as a consequence of): | | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
aspirin pneumonia
virus heart infection | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. STROKE - MULTI INFARCT | | | | | | | | Approximate Interval Between Onset and Death
years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Hypertension | | | | | | | | Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Dementia | | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
aspirin pneumonia
virus heart infection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Grumpy's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Jeffrey N. Zimbrun | | | | | | 29c. License number
D25216 | | 29d. Date signed (Month, Day, Year)
August 9/2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JERRY STOLS MD 3460 ELICOTT CENTER DRIVE SUITE 103
ELICOTT CITY, MD 21043 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 10 2000 | | | | 32. Registrar's Signature
Jennifer Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27070

amend item 5 per fh G787 9/5/00 yf

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JULIA ANNE PETERSON | | | | 2. Date of Death
Month Day Year
AUG 21 2000 | | | | 3. Time of Death
10:45 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BETHESDA | | | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
196-14-2265 64 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 22, 1922 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Frederick | | 10c. City, Town or Location
Smithsburg | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
13501 John Kline Rd. | | | | 10f. Zip Code
21783 | | | | 10g. Citizen of What Country?
U.S.A | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6-2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Social Worker | | | | 16b. Kind of Business/Industry
Health Dept. | | | |
| 17. Father's Name (First, Middle, Last)
Jessie E. Kohler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anne V. Wright | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Wayman T. Peterson (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13501 John Kline Rd. Smithsburg, Md. 21783 | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory | | Date
Aug. 23 2000 | | 20c. Location - City or Town, State
Smithsburg, Md. | | | | | |
| 21. Signature of Funeral Service Licensee
Dennis L. Davis | | | | 22. Name and Address of Facility
Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Dennis L. Davis MD | | | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
8/22/00 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GAUAM S. NAYAK, LT, MC, USN | | | | NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 25 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27071

| | | | | | |
|---|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>JULIA A ROMANO</u> | | 2. Date of Death
Month <u>AUG.</u> Day <u>7</u> Year <u>2000</u> | | 3. Time of Death
<u>1609</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>HOWARD COUNTY GENERAL HOSPITAL</u> | | 4b. City, Town, or Location of Death
<u>COLUMBIA</u> | | 4c. County of Death
<u>HOWARD</u> |
| Funeral
Director | 5. Social Security Number
<u>215-42-9954</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>55</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<u>AUG 22, 1944</u> | | 9. Birthplace (State or Foreign Country)
<u>Pennsylvania</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
<u>Maryland</u> | | 10b. County
<u>Howard</u> | | 10c. City, Town or Location
<u>Columbia</u> | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
<u>10478 Fair Oaks</u> | | | 10f. Zip Code
<u>21044</u> | | 10g. Citizen of What Country?
<u>United States</u> |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12th</u> | | College (1-4 or 5+)
<u>Secretary</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>McDonough School</u> | |
| 17. Father's Name (First, Middle, Last)
<u>John Dahlgreen</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Julia Dahlgreen Glover</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Michelle Abernathy (daughter)</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>10478 Fair Oaks Columbia, MD 21044</u> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Bethany Cemetery</u> | | 20c. Location - City or Town, State
<u>8/11/00 New Windsor, MD</u> | |
| 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | 22. Name and Address of Facility
<u>Burrier-Queen Funeral Directors</u>
<u>1212 West Old Liberty Rd. Winfield, MD 21784</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <u>metastatic breast cancer</u> | | | Approximate Interval Between Onset and Death
<u>> 5 years</u> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<u>[Signature] M.D.</u> | | 29c. License number
<u>026621</u> | | 29d. Date signed (Month, Day, Year)
<u>AUG 7, 2000</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>GARY MILLIS MD 3460 ELLICOTT CENTER DR. ELLICOTT CITY, MD 21043</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 11 2000</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27072

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Herbert Rice, Jr. | | | | 2. Date of Death
Month August Day 6 Year 2000 | | 3. Time of Death
1:58AM | |
| | 4a. Facility Name (If not institution, give street and number)
Fairhaven | | | | 4b. City, Town, or Location of Death
Sykesville | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
214-01-5709 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 3, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1230 Uniontown Rd. | | 10f. Zip Code
21158 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
engineer/ executive | | 16b. Kind of Business/Industry
petroleum | | 17. Father's Name (First, Middle, Last)
George Herbert Rice, Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Agnes Gill | | 19a. Informant's Name/Relationship (Type, Print)
Stephanie R. White/ daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 525 Westminster, MD 21158 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc. | | 20c. Date
8/8/00 | | 20d. Location - City or Town, State
Hampstead, MD | | 21. Signature of Funeral Service Licensee
<i>Catherine D. Hartzler</i> | |
| | 22. Name and Address of Facility
Hartzler Funeral Home
310 Church St. New Windsor, MD 21776 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Congestive Heart Failure
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Aneurysm
Pulmonary Disease | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Robert L. Morris M.D.</i> | |
| | 29c. License number
032882 | | 29d. Date signed (Month, Day, Year)
8/7/2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert L. Morris 114 Business Center Dr. Reisterstown, MD 21138 | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | |
| State Registrar | 32. Registrar's Signature
<i>Benita B. Sparks</i> | | 33. Date of Death
AUG 14 2000 | | 34. Registrar's Signature
<i>Benita B. Sparks</i> | | 35. Date of Death
AUG 14 2000 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27073

| | | | | | | | | | | | |
|---|---|---|--|---|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS EDWARD SPIES, SR. | | | | 2. Date of Death
Month Day Year
AUGUST 03, 2000 | | | | 3. Time of Death
11:41 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
29744 APPLE DRIVE | | | | 4b. City, Town, or Location of Death
CORDOVA | | | | 4c. County of Death
TALBOT | | |
| Funeral
Director | 5. Social Security Number
214-28-1283 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 27, 1934 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
CORDOVA | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
29744 APPLE DRIVE | | | | 10f. Zip Code
21625 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1951-72 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
AMMUNITIONS SPECIALIST | | | | 16b. Kind of Business/Industry
U.S. MILITARY | | | |
| 17. Father's Name (First, Middle, Last)
ELMER SPIES | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DORIS PARDOE | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
VALERIE WILLEY/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2414 PARLIAMENT DRIVE, ABINGDON, MD 21009 | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION CENTER | | Date
8/8/00 | | 20c. Location - City or Town, State
CHESTER, MD | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Man E. Van 8 CKSP</i> | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN, & NEWMAN FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>Intra-oral gunshot wound</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<u>Limited</u>
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
8-3-2000 | | 28b. Time of Injury
1021 PM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
subject shot self | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Residence | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
29744 Apple Drive, Talbot County, Maryland | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>Stephen S. Radentz, M.D.</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 04, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
AUG 07 2000 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

588
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Wallace William Skinner

August 7 2000 1545

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

214-32-2479

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

83

8. Date of Birth (Month, Day, Year)

June 5, 1917

9. Birthplace (State or Foreign Country)

Maryland

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1 Dover Brook

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

14. Race - American Indian, Black, White, etc.

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hanging chickens

16b. Kind of Business/Industry

Poultry Plant

17. Father's Name (First, Middle, Last)

John Skinner

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Williams

19a. Informant's Name/Relationship (Type, Print)

Viola W. Skinner / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Dover Brook, Easton, Maryland 21601

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Chapel Cemetery

20c. Location - City or Town, State

8/12/2000 Easton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Respiratory failure

23b. Approximate Interval Between Onset and Death

60 minutes

23c. Due to (or as a consequence of):

aspiration pneumonia

23d. Due to (or as a consequence of):

1 day

23e. Due to (or as a consequence of):

cardiac arrest due to ventricular tachycardia

23f. Due to (or as a consequence of):

myocardial infarction

23g. Due to (or as a consequence of):

Left hemispheric stroke

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicidal 4 Homicidal

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harou Laura Jin

29c. License number

D0055484

29d. Date signed (Month, Day, Year)

08-07-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laura Jin, MD, 19 South Washington St., Easton, Maryland 21601

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

B. Sparks

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27075

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|---|---|--|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillian Irene Sterbanis | | | 2. Date of Death
Month Day Year
August 15 2000 | | 3. Time of Death
11:47 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Charles County Nursing Rehab Center | | | 4b. City, Town, or Location of Death
LaPlata | | 4c. County of Death
Charles | |
| Funeral
Director | 5. Social Security Number
219-46-5410 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 28, 1911 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
Charles | | 10c. City, Town or Location
Cobb Island | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10a. Street and Number
12122 Neale Sound Drive | | | | 10f. Zip Code
20625 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | |
| 17. Father's Name (First, Middle, Last)
George Lancaster Farrell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine L. Quade | | | |
| 19a. Informant's Name/Relationship (Type, Print)
A.J. Perk/Son-in-Law | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4710 Oak Street White Plains, Md 20695 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Ghost Cemetery | | 20c. Location - City or Town, State
8/19/00 Issue, Maryland | | 20d. Date | |
| 21. Signature of Funeral Service Licensee
David C. Echols | | 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A.
P.O. BOX 567 LaPlata, Md 20646 | | 22. License Number
M00945 | | 22. Date | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Coronary Heart Failure
Due to (or as a consequence of):
Coronary atherosclerosis
Due to (or as a consequence of):
Arteriosclerosis
Due to (or as a consequence of):
 | | | | | | | Approximate Interval Between Onset and Death |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
James Burke | | | | 29c. License number
D01009 | | 29d. Date signed (Month, Day, Year)
8-16-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Henry Burke M.D. P.O. Box 2539 LaPlata, Md 20646 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27076

| | | | | | | | | |
|---|--|--|---|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE ALBERT SIX | | | | 2. Date of Death
Month 8 Day 12 Year 2000 | | 3. Time of Death
1107 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Carroll County General Hospital | | | | 4b. City, Town, or Location of Death
Westminster | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
220-28-8042 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 6, 1933 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Carroll | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Keymar | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
967 Francis Scott Key Highway | | | | 10f. Zip Code
21757 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lift truck driver | | 16b. Kind of Business/Industry
Rubber Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Marlin R. Six | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marguerite DeBerry | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Betty L. Six/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
967 Francis Scott Key Highway Keymar, MD 21757 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery | | 20c. Location - City or Town, State
8/15/00 Keysville, MD | | | |
| | 21. Signature of Funeral Service Licensee
Catherine O. Hartzler | | | | 22. Name and Address of Facility
Hartzler Funeral Home
6 E. Broadway Union Bridge, MD 21791 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Coronary artery disease
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):
c. End stage liver disease
Due to (or as a consequence of):
d. Cardiac Arrhythmias | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Catherine O. Hartzler | | 29c. License number
83202 MD | | 29d. Date signed (Month, Day, Year)
8/12/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHERO - S. HOSAIN MD. 412 MALCOLM DRIVE. WESTMINSTER, MD 21157 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
B Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Jeffrey Scott Schillinger

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

PER MEO G786 8-28-00 WR.

Certificate of Death

Reg. No.

00 27077

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|---------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jeffrey Scott Schillinger | | | | 2. Date of Death
Month August Day 20 Year 2000 | | | | 3. Time of Death
2:11 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
West Green Street and Bond Street | | | | 4b. City, Town, or Location of Death
Westminster | | | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
222-60-3206 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
35 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug 30, 1964 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
78 W. Green Street | | | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | | 16b. Kind of Business/Industry
Automobiles | | | |
| 17. Father's Name (First, Middle, Last)
Louis H. Schillinger | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Peggy Fleming | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Louis Schillinger, father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3417 Augusta Rd, Manchester, MD 21102 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kirkridge Cemetery | | Date
8/23 | | 20c. Location - City or Town, State
Manchester, MD | | |
| 21. Signature of Funeral Service Licensee
Sharon Eline M00723 | | | | 22. Name and Address of Facility
Eline Funeral Home
934 South Main St, Hampstead, MD 21074 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MULTIPLE INJURIES | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
8-20-00 | | | | | | | | | | |
| 28b. Time of Injury
1:58 A M | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred
SUBJET JUMPED FROM SCAFFOLDING AROUND CHURCH STEEPLE | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
CHURCH | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
GREEN STREET & BOND ST. WESTMINSTER, CARROLL, CO. MD. | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Stephen S. Radentz, M.D. | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 20, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 22 2000 | | | | 32. Registrar's Signature
Geneva B Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27078

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Deborah Tomlinson-Dixon | | | | 2. Date of Death
Month Day Year
August 13 2000 | | 3. Time of Death
403 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
252-17-8612 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
41 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct 5 1958 | | 9. Birthplace (State or Foreign Country)
GA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
64 Stemmers Run Road | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | 16b. Kind of Business/Industry
M/ACOM | | |
| 17. Father's Name (First, Middle, Last)
Devereaux H. Dixon Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosabel Pusha | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Rosabel Dixon/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1433 Cathy Street Savannah, GA 31415 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn Gardens | | 20c. Location - City or Town, State
8/20 Savannah, GA. | | |
| 21. Signature of Funeral Service Licensee
John K. [Signature] | | | | 22. Name and Address of Facility
Pritts Funeral Home and Chapel
412 Washington Rd Westminster, MD 21157 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Hypoxia Due to (or as a consequence of):
b. Pulmonary metastases Due to (or as a consequence of):
c. Colon Cancer Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Michelle Cicilline MD | | | | 29c. License number
RD 203430 | | 29d. Date signed (Month, Day, Year)
8/13/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Michelle Cicilline 9000 Franklin Square Drive Baltimore Maryland 21237 | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
[Signature] | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27079

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Wilbert White

2. Date of Death

Month Day Year
August 7 2000

3. Time of Death

10:40 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

224-18-2672

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 13, 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 Corner St., P.O. Box 182

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Oyster Shucker

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Joseph White

18. Mother's Name (First, Middle, Maiden Surname)

Eva F. Finchent

19a. Informant's Name/Relationship (Type, Print)

Lorenzo White /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Corner Street, P.O. Box 182, St. Michaels, Md. 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Charles Thomas Cemetery 8/12/2000 St. Michaels, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
P.O. Box 1687, Easton, Maryland 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder

Blindness.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Sparks

29c. License number

H42587

29d. Date signed (Month, Day, Year)

8/9/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell A Schilling 555 Gunwood Dr. Easton MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

B. Sparks

John White

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27080

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|---|--|--|---|--|---|---|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joan Marie Weeks | | | | 2. Date of Death
Month Day Year
08-13-2000 | | | | 3. Time of Death
8:15 pm | | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis Elder Care | | | | 4b. City, Town, or Location of Death
LaPlata | | | | 4c. County of Death
Charles | | |
| Funeral
Director | 5. Social Security Number
217-42-8017 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
55 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year)
01-26-1945 | | 9. Birthplace (State or Foreign Country)
Maryland | | Usual Residence of Decedent
10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland Charles Indian Head 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
17 Glymont Road 20640 United States | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Qualifications Assistant | |
| 16b. Kind of Business/Industry
Regulatory of Brokers and Dealers | | 17. Father's Name (First, Middle, Last)
William Joseph Grabis | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Eleine Cranford | | 19a. Informant's Name/Relationship (Type, Print)
Martha Jane Smith/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
134 Circle Avenue, Indian Head, Maryland 20640 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial Gardens | | Date
August 21, 2000 | | 20c. Location - City or Town, State
Waldorf, Maryland | | 21. Signature of Funeral Service Licensee
M00668 | | 22. Name and Address of Facility
Williams Funeral Home, P.A. 20640
4270 Hawthorne Road, Indian Head, Maryland | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. RENAL CELL CANCER
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Dr. Krishan Mathur | | 29c. License number
028352 | |
| 29d. Data signed (Month, Day, Year)
August 16, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Krishan Mathur 3500 Old Washington Road, Suite 102, Waldorf, Maryland 20602 | | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
B. Spach | | State Registrar | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27081

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Levin Barrett Wingate | | | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
09:35 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
505 GAY STREET | | | | 4b. City, Town, or Location of Death
CAMBRIDGE | | 4c. County of Death
DORCHESTER | |
| Funeral
Director | 5. Social Security Number
218-64-3655 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 19, 1954 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
505 Gay Street | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
US | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed | | 16b. Kind of Business/Industry
Lawn Maintenance | | | |
| | 17. Father's Name (First, Middle, Last)
Raymond Smith Wingate, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Sedgewick | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nickol A. Wingate Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 198 Trappe, Maryland 21673 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Cemetery | | 20c. Location - City or Town, State
8/16/00 Cambridge, Maryland | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 21613 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | |
| | State Registrar | | | | | | | |

ORIGINAL

March 5, 1904

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AMEND#14 PER F.H. G786 8-29-2000 JAB
Amended Item# 22 per FH G786 8-28-00 WJJ

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27082

| | | | | | | | | |
|---|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Daisy B. Allen | | | | 2. Date of Death
Month Day Year
8 22 2000 | | 3. Time of Death
1:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
5248 Darien Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-22-8441 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
10-9-1926 | 9. Birthplace (State or Foreign Country)
Md |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
5248 Darien Road | | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U S A | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: U S A BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unk College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housekeeping | | | 16b. Kind of Business/Industry
Unk | |
| 17. Father's Name (First, Middle, Last)
Clarence White | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Gant | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sylvia M. Dyson- Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5248 Darien Road Baltimore, Md 21206 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Veteran 8-29-00 Owings Mills, Md | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
Wheeler Edmond | | | | 22. Name and Address of Facility
West 4300 Wabash Ave. Balto., Md 21215
March F.H. East 1101 E. North Ave. | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. adenocarcinoma, prostate, lung origin
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
1 MONTH |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Dr. Burtel M.D. Physician | | | | 29c. License number
019714 | | 29d. Date signed (Month, Day, Year)
8/23/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MILMARL ARIEL JYOUNG 4440 EASTMAN AVE BALTIMORE, MD 21227 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBH. 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27083

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|---------------------------------------|---|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Elijah Alston</i> | | | | 2. Date of Death
Month Day Year
<i>AUGUST 22, 2000</i> | | 3. Time of Death
<i>12:53 AM</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>CIVISTA MEDICAL CENTER</i> | | | | 4b. City, Town, or Location of Death
<i>LAPLATA</i> | | 4c. County of Death
<i>CHARLES</i> | | |
| Funeral
Director | 5. Social Security Number
<i>239-32-5545</i> | 6. Sex
<i>1</i> M <i>2</i> F | 7. Age (In yrs. last birthday)
<i>73</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>April 16, 1927</i> | | 9. Birthplace (State or Foreign Country)
<i>North Carolina</i> | |
| | Usual Residence of Decedent | | | | | | | | 10d. Inside City Limits
<i>1</i> Yes <i>2</i> No |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Charles</i> | | 10c. City, Town or Location
<i>White Plains</i> | | | | |
| | 10e. Street and Number
<i>10160 Griffith Lane</i> | | | | 10f. Zip Code
<i>20695</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<i>1</i> Never Married <i>2</i> Married
<i>3</i> Widowed <i>4</i> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<i>1</i> Yes <i>2</i> No
If Yes, Give Year or Dates: <i>Navy</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<i>1</i> Yes <i>2</i> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Laborer</i> | | 16b. Kind of Business/Industry
<i>Salvage & Waste Co.</i> | | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Joseph Jones</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Lillie Alston</i> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (daughter)
<i>Ms. Terri Alston</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>10160 Griffith Lane White Plains, Md. 20695</i> | | | | |
| | 20a. Method of Disposition
<i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State
<i>4</i> Donation <i>5</i> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Garrison Forest</i> | | 20c. Location - City or Town, State
<i>8/28/2000 Owings Mills, Md.</i> | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Joseph L. Russ</i> | | | | 22. Name and Address of Facility
<i>Joseph L. Russ Funeral Home
2222 W. North Ave. Balto Md. 21216</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. cardiorespiratory arrest</i>
Due to (or as a consequence of):
<i>b. Lung cancer</i>
Due to (or as a consequence of):
<i>c.</i>
Due to (or as a consequence of):
<i>d.</i>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<i>1</i> Yes <i>2</i> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<i>1</i> Yes <i>2</i> No | |
| 25. Was case referred to medical examiner?
<i>1</i> Yes <i>2</i> No | | 26. Place of Death (Check only one)
Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>8</i> Other (Specify) | | | | | | | |
| 27. Manner of Death
<i>1</i> Natural <i>5</i> Pending investigation
<i>2</i> Accident <i>6</i> Could not be determined
<i>3</i> Suicide <i>4</i> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<i>1</i> Yes <i>2</i> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Waheed Akthar M.D.</i> | | | | 29c. License number
<i>D-31675</i> | | 29d. Date signed (Month, Day, Year)
<i>8-22-00</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>WAHEED U. AKTHAR M.D. WHITE PLAINS MEDICAL CNTR. WHITE PLAINS MD. 20695</i> | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>AUG 28 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27084

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------------|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELIZABETH ANTON | | | | 2. Date of Death
Month Day Year
AUGUST 26, 2000 | | | | 3. Time of Death
1:34 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
215-16-7480 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept 9, 1918 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Pikesville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
908 Adana Road | | | | 10f. Zip Code
21208 | | | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Medical Secretary | | | | 16b. Kind of Business/Industry
Medical | | |
| 17. Father's Name (First, Middle, Last)
Thomas C. Plummer | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emily Parsons | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Judith A. Davies | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14022 Greencroft Lane Hunt Valley, MD 21030 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | Date
8/29/00 | | 20c. Location - City or Town, State
Woodlawn, Maryland | | |
| 21. Signature of Funeral Service Licensee
Stephen M. Jenkins | | | | | 22. Name and Address of Facility
Eline Funeral Home
11824 Reisterstown Road Reisterstown, MD 21136 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Clifford Faber, MD | | | | | 29c. License number
024970 | | | 29d. Date signed (Month, Day, Year)
AUGUST 26, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CLIFFORD FABER, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MARYLAND 21133 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | | 32. Registrar's Signature
[Signature] | | | | | |


Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 00 27085
Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--|---|---|--|---|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Ann Autrey | | | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
3:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
8074 Greenbud Lane | | | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
216-48-8970 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
40 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 25, 1959 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Glen Burnie | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
8074 Greenbud Lane | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (9-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Medical Receptionist | | | 16b. Kind of Business/Industry
Doctors Office | | | |
| | 17. Father's Name (First, Middle, Last)
Frank Spadaro | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Rider | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Kenneth Autrey Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8074 Greenbud Lane Glen Burnie, MD 21061 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | Date
8/26/2000 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Singleton Funeral Home, P.A.
1 Second Avenue, S.W.
Glen Burnie, Maryland 21061 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) Breast Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
1 year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D39505 | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Indrisha Marwan 1600 Crain Hwy, Glen Burnie, MD 21061 | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27086

| | | | | | | | | |
|--|--|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Catherine Ament</u> | | | | 2. Date of Death
Month <u>August</u> Day <u>25</u> Year <u>2000</u> | | 3. Time of Death
<u>6:45 P.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Riverview Care Center</u> | | | | 4b. City, Town, or Location of Death
<u>Essex</u> | | 4c. County of Death
<u>Baltimore</u> | |
| Funeral
Director | 5. Social Security Number
<u>218226914</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>February 16, 1927</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
<u>Maryland</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Middle River</u> | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number
<u>72 S. Hawthorn Road</u> | | | | 10f. Zip Code
<u>21220</u> | | 10g. Citizen of What Country?
<u>U. S. A.</u> | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Clerk</u> | | 16b. Kind of Business/Industry
<u>Clothing</u> | | |
| 17. Father's Name (First, Middle, Last)
<u>George Fritsch</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Turek</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Lawrence Ament (Husband)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>72 S. Hawthorn Road Middle River, MD 21220</u> | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Oaklawn Cemetery</u> | | Date
<u>8/28</u> | | 20c. Location - City or Town, State
<u>Baltimore, Maryland</u> | |
| 21. Signature of Funeral Service Licensee
<u>Michael C. Saffian</u> | | | | 22. Name and Address of Facility
<u>Bruzdinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221</u> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Arteriosclerotic Coronary Vascular Disease</u>
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Breast carcinoma. Dementia</u>
<u>Degenerative Joint Disease</u>
<u>Peripheral Vascular Disease</u> | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<u>Michael Saffian</u> | | | | 29c. License number
<u>D19667</u> | | 29d. Date signed (Month, Day, Year)
<u>8-26-00</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>5517 A Ritchie Highway Brooklyn Park, MD 21225</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 28 2000</u> | | | | 32. Registrar's Signature
<u>Benny B. Sparks</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27087

TIMOTHY BELL

8-28-00WJJ

Amended item #10a per ME G786

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|---|---|---|---|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TIMOTHY W. BELL | | | | 2. Date of Death
Month AUG. Day 6, Year 2000 | | | | 3. Time of Death
2245 PM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
30474 REVELLS NECK ROAD | | | | 4b. City, Town, or Location of Death
WESTOVER | | | | 4c. County of Death
SOMERSET | | | | | | |
| Funeral
Director | 5. Social Security Number
206-12-1235 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 6, 1914 | | 9. Birthplace (State or Foreign Country)
VA | | | | | | |
| | 10a. State
MD | | | | 10b. County
Somerset | | 10c. City, Town or Location
Westover | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | |
| 10e. Street and Number
30474 Revels Neck Road | | | | 10f. Zip Code
21871 | | | | 10g. Citizen of What Country?
USA | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
crane operator | | | | 16b. Kind of Business/Industry
electrical | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Charles W. Bell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lenna Brasweo | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Penn Street Baltimore, MD 21201 | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Hemopericardium
Due to (or as a consequence of):</td> </tr> <tr> <td>b. Ruptured Myocardial Infarct
Due to (or as a consequence of):</td> </tr> <tr> <td>c. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Hemopericardium
Due to (or as a consequence of): | b. Ruptured Myocardial Infarct
Due to (or as a consequence of): | c. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of): | d. |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Hemopericardium
Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | b. Ruptured Myocardial Infarct
Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | c. Hypertensive Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of): | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Dennis Chutemo | | | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUG. 8, 2000 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutemo 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | 32. Registrar's Signature
B Sparks | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27088

| | | | | | | | | |
|--|---|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EARL ALLEN BLACKWELL, JR | | | | 2. Date of Death
Month Day Year
08-26-00 | | 3. Time of Death
5:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
7120 MINNA ROAD | | | | 4b. City, Town, or Location of Death
GWYNN OAK | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-12-0496 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
17 Yrs. | | 8. Date of Birth (Month, Day, Year)
08-06-23 | |
| | 9. Birthplace (State or Foreign Country)
VA | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
GWYNN OAK | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | | 10b. County
BALTIMORE | | | 10c. City, Town or Location
GWYNN OAK | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
7120 MINNA ROAD | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 TH GRADE
College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DEPT. OF DEFENSE | | 16b. Kind of Business/Industry
GOVERNMENT | | |
| 17. Father's Name (First, Middle, Last)
EARL BLACKWELL, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIOLA SMITH | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DORETHA BLACKWELL WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7120 MINNA RD, BALTO. MD. 21207 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST | | 20c. Location - City or Town, State
8:30.00 OWINGS MILLS, MD | | |
| 21. Signature of Funeral Service Licensee
Vaughn C. H. | | | | 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Larry Waterbury, M.D. | | | | 29c. License number
DO 9559 | | 29d. Date signed (Month, Day, Year)
8/28/2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LARRY WATERBURY, MD, JN BMC, 4940 EASTERN, BALTO, MD 21224 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27089

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------|--|---------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Barnes Jr. | | | | 2. Date of Death
Month August Day 20 , Year 2000 | | | | 3. Time of Death
11:07 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Hospital. | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-96-2006 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
20 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
8-18-80 | | 9. Birthplace (State or Foreign Country)
Md. | | Usual Residence of Decedent | | 10a. State
Md. | | 10b. County
BALTIMORE | |
| 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
270 ROBINSON ST. | | 10f. Zip Code | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CONTRACTING | | 16b. Kind of Business/Industry
CARPET | | 17. Father's Name (First, Middle, Last)
John Wesley Barnes Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
TAMMY PRICE | | 19a. Informant's Name/Relationship (Type, Print)
John Wesley Barnes Sr. | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1619 OLD EASTERN AVE BALTO. MD. 21221 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SACRED HEART 8250 DUNDALK MD. | | 20c. Location - City or Town, State | | 21. Signature of Funeral Service Licensee
Wesley Chair | | |
| 22. Name and Address of Facility
CHAVIS FUNERAL HOME 2007 EASTERN BALTO. 21221 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
HANGING | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
INSPECTION
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/20/00 | | 28b. Time of Injury
1030 A.M. | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT HANGED SELF | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
270 S. ROBINSON ST BALTIMORE MD | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
J.A. Pinn. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 21, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | |
| 32. Registrar's Signature
Bernie S. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27090

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|--|---|---|----|-----------------------|----------------------------------|--|----|------------------------|----------------------------------|----|--|----------------------------------|----|--|----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Viola Bush | | | | 2. Date of Death
Month Aug Day 19 Year 2000 | | 3. Time of Death
13:28 | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
University of Md. | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-16-3601 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 17, 1916 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | | | | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2501 Violet Ave. Apt. 1207 | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Afro-American | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Outside Home | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
William Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Harcum | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) (son)
Mr. Oliver Johnson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
603 S. Fremont Ave. Balto. Md. 21230 | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville VA Cem. | | 20c. Location - City or Town, State
8/25/2000 Crownsville, Md. | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>cardiac arrest</td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>cardiac disease</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | cardiac arrest | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. | cardiac disease | Due to (or as a consequence of): | c. | | Due to (or as a consequence of): | d. | | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | cardiac arrest | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| | b. | cardiac disease | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and Title of certifier
Joseph L. Russ | | | | 29c. License number
D38686 | | 29d. Date signed (Month, Day, Year)
8/24/00 1:05 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
419 W. Redwood St. Balto. MD 21201 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Geneva B. Sparks | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27091

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARIA M. BRUFFEY | | | | 2. Date of Death
Month Day Year
August 22, 2000 | | 3. Time of Death
7:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Towson | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
214-40-4547 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
97 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 13, 1903 | | |
| | 9. Birthplace (State or Foreign Country)
Md. | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8229 Carrbridge Cr. | | 10f. Zip Code
21204 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Education | | | | | |
| 17. Father's Name (First, Middle, Last)
Frank K. Moore | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie M. Little | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Frank Simmons/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8229 Carrbridge Cr. Towson, Md. 21204 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Chapel U.M. | | 20c. Date
8/25/00 | | 20d. Location - City or Town, State
Joppa, Md. | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Pneumonia</u>
Due to (or as a consequence of):
b. <u>COPD</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Sub dural Hematoma</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D44796 | | 29d. Date signed (Month, Day, Year)
8-24-00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAMMED AHMED 9512 HARBOR RD, BALTIMORE 21234 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27092

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|--------------------------------------|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Vernon Edwin Bush | | | | 2. Date of Death
Month 8 Day 23 Year 00 | | | | 3. Time of Death
250/p | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Towson | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-03-2474 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
Aug. 3, 1910 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore City | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3516 Dudley Avenue | | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | | | 16b. Kind of Business/Industry
Industrial | | | |
| | 17. Father's Name (First, Middle, Last)
Edwin M. Bush | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maude Jones | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mr. Robert J. Bush (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13525 Fork Road Baldwin, Maryland 21013 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer Cemetery | | Date
8/26/2000 | | 20c. Location - City or Town, State
Baltimore Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md. 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

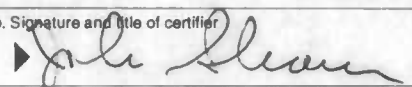
b. CARDIOMYOPATHY
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death

3 yrs

5 yrs | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D27838 | | | | 29d. Date signed (Month, Day, Year)
8/24/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN S. HARRIS, D.O. 518 CAMP MEADOW RD LINTHicum, MD 21090 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | | | |

ORIGINAL

Mr. E.
Mr. B.

Mr. C. D. Smith, President
Mr. J. H. Jones, Secretary

1900

1900

1900

1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27, 28a-E PER MEO G787 9=11-00 WR.

Reg. No.

00 27093

| | | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GREGORY ALLEN BUTCHER | | | | 2. Date of Death
Month Day Year
AUGUST 25, 2000 | | | | 3. Time of Death
02:33 AM | |
| | 4a. Facility Name (If not institution, give street and number)
3601 GREENMOUNT AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
382-60-1384 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
46 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 29, 1953 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
3601 Greenmount Ave | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed | | | | 16b. Kind of Business/Industry
Cabinet Maker | | |
| 17. Father's Name (First, Middle, Last)
James Herbert Butcher | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Betty Fern Gillespie | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Nikki Chilcoat/sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15007 Lavale Road Monkton, MD 21111 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | Date
08/28/00 | | 20c. Location - City or Town, State
Towson, Maryland | | |
| 21. Signature of Funeral Director
 Stephen D. Coster MD1122 | | | | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

NARCOTIC AND ALCOHOL INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8-25-00 | | 28b. Time of Injury
UNKNOWN | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3601 GREENMOUNT AVE. BALTIMORE CITY, MD | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 Stephen S. Radentz, M.D. | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
AUGUST 25, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 Dawn B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27094

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ivan Timothy Cruse | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
2308 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Shock Trauma | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-08-9581 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
16 Yrs. | | 8. Date of Birth (Month, Day, Year)
04/11/1984 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3726 East Lombard Street | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10
College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
Education | | 17. Father's Name (First, Middle, Last)
Unknown | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Annie Ernestine Cruse | | 19a. Informant's Name/Relationship (Type, Print)
Iva T. Cruse / Grandmother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3726 E. Lombard St., Baltimore, Maryland 21224 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | 20c. Date
08/31/00 | | 20d. Location - City or Town, State
Landsdowne, Maryland | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Derrick C. Jones Funeral Home
4611 Park Heights Ave., Baltimore, Maryland 21215 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Gunshot Wound of Chest | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24a. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24c. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 24d. Date of Injury (Month, Day, Year)
8/24/00 | | 24e. Time of Injury
2220 | | 24f. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Street | | |
| 24h. Location (Street and Number or Rural Route Number, City or Town, State)
500 Block of Preston Street, Baltimore, Md. | | 25a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 25b. Signature and title of certifier

Joseph Pestaner, M.D. | | 25c. License number
O.C.M.E. | | |
| 25d. Date signed (Month, Day, Year)
August 25, 2000 | | 26. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | 26a. Data filed (Month, Day, Year)
AUG 28 2000 | | 26b. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27095

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WALTER A. COOPER | | | | 2. Date of Death
Month Day Year
8 24 00 | | 3. Time of Death
8:50 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
2 HOPKINS STREET | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
212-28-0349 | | 6. Sex
M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT. 7, 1929 | |
| | Usual Residence of Decedent
10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
2 HOPKINS STREET | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1951-1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ASSISTANT GENERAL SUPERVISOR | | 16b. Kind of Business/Industry
GAS & ELECTRIC CO. | | | |
| | 17. Father's Name (First, Middle, Last)
ARTHUR COOPER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VERA DEAL | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BEATRICE COOPER (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 HOPKINS STREET, GLEN BURNIE, MD. 21061 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLEN HAVEN MEMORIAL PARK | | Date
AUG. 29, 2000 | | 20c. Location - City or Town, State
GLEN BURNIE, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> M01220 | | | | 22. Name and Address of Facility | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) <i>Metastatic malignant mesothelioma</i>
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State
Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>William J. Hicken MD</i> | | 29c. License number
D04964 | |
| | | | 29d. Date signed (Month, Day, Year)
8/25/00 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM J. HICKEN, MD. 900 CATON AVE BALTIMORE, MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
<i>[Signature]</i> 21229 | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27096

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|--------------------------------------|--|--|---|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN VERNON CREEK | | | | 2. Date of Death
Month AUG. Day 19 Year 2000 | | | | 3. Time of Death
3:14 PM | |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
212-10-6104 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
6-29-1913 | | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
210 ELIZABETH AVE. | | | | 10f. Zip Code
21225 | | | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ENGINEER | | | | 16b. Kind of Business/Industry
A.A. COUNTY SCHOOLS | |
| | 17. Father's Name (First, Middle, Last)
JAMES CREEK | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH CREEK | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DOROTHY CREEK (SPOUSE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
210 ELIZABETH AVE. BALTO. MD 21225 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEM. | | Date
8-25-2000 | | 20c. Location - City or Town, State
BROOKLYN MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Eugene Walker</i> | | | | 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL SERV
1300 EUTAW PLACE BALTO. MD 21217 | | | | | |
| | 23. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
<i>Cancer of the Lungs</i>
Due to (or as a consequence of):
{
b. <i>metastasis to liver</i>
Due to (or as a consequence of):
c. <i>Alzheimer's disease</i>
Due to (or as a consequence of):
d. | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
051596 | | 29d. Date signed (Month, Day, Year)
September 25th 2000 | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
K. AMBALAVANAR, HARBOR FAMILY CARE SOUTH Hanover Street 2900, BALTIMORE | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27097

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dimitri Arthur Davenport Sr.

2. Date of Death

Month Day Year
August 24, 2000

3. Time of Death

11:08 A.M.

4a. Facility Name (If not institution, give street and number)

2004 Eutaw Place, Apartment 1B

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-56-5488

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 3, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2004 Eutaw Place APT 1B

10f. Zip Code

21217

10g. Citizen of What Country

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shop Steward

16b. Kind of Business/Industry

Private Co.

17. Father's Name (First, Middle, Last)

Cecil Davenport

18. Mother's Name (First, Middle, Maiden Surname)

Cora Jane Johnson

19a. Informant's Name/Relationship (Type, Print) (Sister)

Ms. Ruby Fowlkes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

222 Center St. Balto, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

9/1/2000

20c. Location - City or Town, State

Balto, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Gene G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27098

| | | | | | | | | | | |
|--|---|--|---|--------------------------------|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Dorothy Durant | | | | 2. Date of Death
Month Day Year
August 23 2000 | | | | 3. Time of Death
13:45 P | |
| | 4a. Facility Name (If not institution, give street and number)
Mercy Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore City | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
219-50-0390 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 14, 1930 | | 9. Birthplace (State or Foreign Country)
SOUTH CAROLINA | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE CITY | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
751 WEST SARATOGA STREET | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA. | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH GRADE
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
MOSS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EDNA MCGILL | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CLIFTON DURANT (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3803 PATTERSON AVENUE, BALTIMORE, MD 21207 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODLAWN CEMETERY | | 20c. Date
8-28-00 | | 20d. Location - City or Town, State
BALTIMORE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO, MD 21217 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| | Immediate Cause (Final disease or condition resulting in death)
uterine Cancer | | | | | | | | Five years | |
| | Due to (or as a consequence of):
Malignant Pleural Effusion | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
M | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Dwight IM M.D. | | | | | | | | | | |
| 29c. License number
D0043934 | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
August 23, 2000 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DWIGHT IM 301 ST. PAUL PLACE BALTIMORE, MD 21202 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | | | | | | | |
| 32. Registrar's Signature
Benita A. Sparks | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#25 per PHYG787 9/21/2000 EW

Certificate of Death

Reg. No. 00 27099

| | | | | | | | | |
|---|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VIVIAN F. DOCK. | | | | 2. Date of Death
Month Day Year
8 25 00 | | 3. Time of Death
0520 | |
| | 4a. Facility Name (If not institution, give street and number)
BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-48-1640 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT. 19, 1948 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
248 NORTH PAYSON STREET | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA. | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10th GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
STITCH WORKER | | 16b. Kind of Business/Industry
CLOTHING MANUFACTURING | | | | |
| 17. Father's Name (First, Middle, Last)
RAYMOND | | 18. Mother's Name (First, Middle, Maiden Surname)
DOCK SR. ESSIE MAE HILLER | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
GEORGE JAMES (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5055 C. REMBERTON ST. VA. BEACH, VA. 23455 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. Location - City or Town, State
8-30-00 LANSDOWNE, MARYLAND | | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE. BALTO. MD. 21217 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End stage Carcinoma of Pancreas
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Salvatore Raiti MD | | 29c. License number
D12753 | | 29d. Date signed (Month, Day, Year)
8/25/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SALVATORE RAITI Bon Secours Emergency Dept. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27100

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Henry DeLong | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1209 Berk Avenue | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-20-1772 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 22, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1209 Berk Avenue | | 10f. Zip Code
21237 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII
If Yes, Give Year or Dates: Korean | |
| To Be Completed by
Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
11 Years | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrician | | | | 16b. Kind of Business/Industry
Construction | | | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
George DeLong | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Condon | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Naomi J. DeLong (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1209 Berk Avenue Rosedale, Maryland 21237 | | | |
| To Be Completed by
Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Park Cem. 8/26/2000 | | 20c. Location - City or Town, State
Dorsey, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| To Be Completed by
Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>esophageal cancer</u>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
9 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CAD
BPH | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by
Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by
Physician/Medical Examiner | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by
Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
028097 | | 29d. Date signed (Month, Day, Year)
8/23/00 | |
| To Be Completed by
Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1516 Meritt Blvd Balt. Md. 21222 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIE
EVERETTState of Maryland, Department of Health and Mental Hygiene
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G787 9-7-00 WR.
Certificate of Death

Reg. No.

00 27101

| | | | | | |
|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIE EVERETT | | 2. Date of Death
Month Day Year
AUGUST 7, 2000 | | 3. Time of Death
4:00A.M. |
| | 4a. Facility Name (If not Institution, give street and number)
JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
unk | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | 8. Date of Birth (Month, Day, Year)
Dec 5, 1948 | 9. Birthplace (State or Foreign Country)
unk |
| | Usual Residence of Decedent | | | | |
| 10e. State
unk | | 10b. County
unk | 10c. City, Town or Location
unk | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number
unk | | 10f. Zip Code
unk | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
unk
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk College (1-4 or 5+) unk | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk | |
| 16b. Kind of Business/Industry
unk | | 17. Father's Name (First, Middle, Last)
unk | | 18. Mother's Name (First, Middle, Maiden Surname)
unk | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Penn Street Baltimore, MD 21201 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Date | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | HEAD INJURIES
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
7-20-00 | | 28b. Time of Injury Found: P 1:10 M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: OUTSIDE | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
100 HOLIDAY ST. BALTIMORE, CITY, MARYLAND | | 29e. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
Stephen S. Radentz, M.D. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 9, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | |
| 32. Registrar's Signature
Steve B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27102

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FERN RENEE ELLIOTT | | | | 2. Date of Death
Month Day Year
AUG. 5, 2000 | | 3. Time of Death
1449 PM | |
| | 4a. Facility Name (If not institution, give street and number)
3760 DOLFIELD AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
unk | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
46 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
July 20, 1954 | 9. Birthplace (State or Foreign Country)
unk | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
5416 Wabash Ave #D3 | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status unk
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk College (1-4 or 5+) unk | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unk | | 16b. Kind of Business/Industry
unk | | |
| 17. Father's Name (First, Middle, Last)
unk | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unk | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Penn Street Baltimore, MD 21201 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
in state | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Narcotic and Alcohol Intoxication
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 8/5/00 | | 28b. Time of Injury
Found: 2:00P | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Unknown | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
3760 Dolfield Ave. Balto. MD. | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Joseph Pestaner, MD | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUG. 6, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
B Sports | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-Certificate of Death

PER MEO 6787 9-12-00 WR. 00 27103

Reg. No.

| | | | | | | | | | | | |
|---|---|--|---|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jerome Epps Jr. | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | | | 3. Time of Death
1525 pm | | |
| | 4a. Facility Name (If not institution, give street and number)
300 East Madison Street- Central Booking | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
219-21-4197 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
27 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/23/1972 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
4353 Reisterstown Road | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | | | 16b. Kind of Business/Industry
Construction | | | |
| 17. Father's Name (First, Middle, Last)
Jerome Epps Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jessie L. Gamble | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jessie L. Epps / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4353 Reisterstown, Rd., Baltimore, Maryland 21215 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | | | 20c. Date
08/31/00 | | 20d. Location - City or Town, State
Landsdowne, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Derrick C. Jones Funeral Home
4611 Park Heights Ave., Baltimore, Maryland 21215 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

HANGING

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. {
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
Found: 8-24-00 | | 28b. Time of Injury
Found: 3:10 P | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT HANGED SELF | |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
CENTRAL BOOKING | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
300 E. MADISON ST., BALTIMORE., MD. | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier
 | |
| 29c. License number
O.C.M.E. | | | | | | | | | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27104

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>MARY LOUISE EVANS</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>18</i> Year <i>2000</i> | | 3. Time of Death
<i>11:15 PM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Sinai Hospital of Baltimore</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>W/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>215 30 9568</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>65</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>June 29, 1935</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>Maryland</i> | | 10b. County
<i>W/A</i> | | 10c. City, Town or Location
<i>Baltimore</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>5315 WABASH AVE</i> | | | | 10f. Zip Code
<i>21215</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>SECRETARY</i> | | 16b. Kind of Business/Industry
<i>Amalgamated Laundry Workers Union</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>LINWOOD NEWMAN</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>ELIZABETH BANKS</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>ROBERT E. EVANS / HUSBAND</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5315 WABASH AVE BALTIMORE, MARYLAND 21215</i> | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Garrison Forest Veterans Cemetery</i> | | Date
<i>8-25-2000</i> | | 20c. Location - City or Town, State
<i>Baltimore, Md</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Gerry Harris</i> | | | | 22. Name and Address of Facility
<i>CHATHAM - HANCO Funeral Home
5340 REISTERSTOWN ROAD
BALTIMORE, MD 21215</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | 24 hrs |
| a. <i>Anoxic brain injury</i>
Due to (or as a consequence of): | | | | | | | | 24 hrs |
| b. <i>Myocardial infarction</i>
Due to (or as a consequence of): | | | | | | | | 10 years |
| c. <i>Coronary artery disease</i>
Due to (or as a consequence of): | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Baumgardner MD</i> | | | | 29c. License number
<i>RES 000</i> | | 29d. Date signed (Month, Day, Year)
<i>August 18, 2000</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>B. Acosta, MD - Sinai Hospital of Baltimore, Maryland</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 28 2000</i> | | 32. Registrar's Signature
<i>B. Acosta</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27105

Amended Item# 29d per PHYG786 8/28/2000 EW

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERNICE M. FRANSEN | | | | 2. Date of Death
Month Day Year
AUG 3, 2000 | | 3. Time of Death
5:15 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis Eldercare Spa Creek | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
523-64-4402 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 14, 1914 | | |
| | 9. Birthplace (State or Foreign Country)
Colorado | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
35 Milkshake Lane | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
teacher | | 16b. Kind of Business/Industry
education | | | | | |
| 17. Father's Name (First, Middle, Last)
Merrill I. Montgomery | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lula E. Orr | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Spa Creek Center | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
35 Milkshake Lane Annapolis, MD 21403 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Data | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular disease
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
1 wk | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner | | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
Ronald S. Wade | | 29c. License number
032036 | | 29d. Date signed (Month, Day, Year)
8-4-2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gay J. Sprone 2108 N. Dond Drive Charter, MD 21619 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Benita G. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27106

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN GARCIA | | | | 2. Date of Death
Month Day Year
August 06 2000 | | | | 3. Time of Death
01:57 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Peninsula Regional Medical Center | | | | 4b. City, Town, or Location of Death
Salisbury | | | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
UNK | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 6, 1956 | | 9. Birthplace (State or Foreign Country)
unk | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
unk | | 10b. County
unk | | 10c. City, Town or Location
unk | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
unk | | |
| 10e. Street and Number
unk | | | | 10f. Zip Code
unk | | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
unk
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: hispanic | | | | 14. Race - American Indian, Black, White, etc.
Specify: hispanic | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
unk unk | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unk | | | | 16b. Kind of Business/Industry
unk | | |
| 17. Father's Name (First, Middle, Last)
unk | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unk | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Penn Street Baltimore, MD 21201 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Date | | | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/6/00 | | 28b. Time of Injury
0019 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Pedestrian struck by vehicle | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
street | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ocean City Hwy/120th St. Ocean City, MD | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
J. M. Locke | | | | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
August 6, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27107

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|-------------------------------|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Violet Elenore Getz | | | | 2. Date of Death
Month Day Year
AUGUST 24, 2000 | | | | 3. Time of Death
8:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
Riverview Nursing Solutions | | | | 4b. City, Town, or Location of Death
Essex | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
213-48-6816 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 | | 8. Date of Birth (Month, Day, Year)
Oct 24 1906 | | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1225 Rustic Avenue | | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
William Wiegmann | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary E. Gettig | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Doris Kridenoff/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1225 Rustic Avenue, Baltimore MD 21237 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Date
8-26-00 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Cvach/Rosedale Funeral Home
1211 Chesaco Avenue, Baltimore, MD 21237 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Arteriothrombosis
Due to (or as a consequence of):
Ischemic Cardiomyopathy
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
COPD, Dehydration, Malnutrition
HTN, Aortic Stenosis | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
23c. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
23d. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD, Dehydration, Malnutrition
HTN, Aortic Stenosis | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
MD | | | | 29c. License number
D-38754 | | 29d. Date signed (Month, Day, Year)
08-24-2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MALIKA WASSEM 709 EASTERN BLVD, MD-21221 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27108

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eleanor Hochstedt | | | | 2. Date of Death
Month August Day 24 Year 2000 | | 3. Time of Death
1730 | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-40-7960 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
94 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 8, 1906 | |
| | 9. Birthplace (State or Foreign Country)
Cambridge, Md. | | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5616 Birchwood Avenue | | 10f. Zip Code
21214 | | |
| 10g. Citizen of What Country?
United States | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
Florist | | |
| 17. Father's Name (First, Middle, Last)
William H. Rhea | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie M. Thiess | | 19a. Informant's Name/Relationship (Type, Print)
Mary E. Rostek (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5616 Birchwood Avenue Baltimore, Maryland 21214 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
8/28/00 | | 20c. Location - City or Town, State
Baltimore Maryland | | |
| 21. Signature of Funeral Service Licensee
Milton J. Knight | | 22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Coronary Artery Disease
Due to (or as a consequence of):

5 years | | Approximate Interval Between Onset and Death | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
8/28/00 | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Benjamin Cooper | | 29b. Signature and title of certifier
Benjamin Cooper | | 29c. License number
DS0293 | | 29d. Date signed (Month, Day, Year)
August 24 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin Cooper Union Memorial Hospital | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Benjamin Cooper | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27109

| | | | | | |
|---|--|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Frank M. Howell | | 2. Date of Death
Month August Day 23 Year 2000 | | 3. Time of Death
11:39 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL CENTER | | 4b. City, Town, or Location of Death
ROSEDALE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
217-34-9118 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
62 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Nov. 19, 1937 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
7816 Jamesford Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 Years
College (1-4 or 5+) Collega | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Warehouseman |
| | 16b. Kind of Business/Industry
Manufacturing | | 17. Father's Name (First, Middle, Last)
Frank Howell, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Crystal Turnes |
| | 19a. Informant's Name/Relationship (Type, Print)
Patricia Colvin (Ex Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7522 Westfield Road Dundalk, Maryland 21222 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 8/26/2000 | | 20c. Location - City or Town, State
Baltimore, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RENAL INSUFFICIENCY
Due to (or as a consequence of):
b. PERIPHERAL VASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | | | | |
| 29c. License number
RD 204180 | | | | | |
| 29d. Date signed (Month, Day, Year)
August 24, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIVEK SOOD, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | | |
| 32. Registrar's Signature
 | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27110

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Howard Jones</u> | | | 2. Date of Death
Month <u>08</u> Day <u>24</u> Year <u>2000</u> | | 3. Time of Death
<u>1720</u> | | |
| | 4a. Facility Name (If not Institution, give street and number)
<u>University of Maryland</u> | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | | |
| Funeral
Director | 5. Social Security Number
<u>212-10-5890</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>88</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>01-20-12</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>MD</u> | | 10a. State
<u>MD</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<u>1647 N. APPLETON STREET</u> | | 10f. Zip Code
<u>21217</u> | | |
| 10g. Citizen of What Country?
<u>USA</u> | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>BLACK</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12 TH GRADE</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>CHAUFFER</u> | | 16b. Kind of Business/Industry
<u>BALTIMORE CITY</u> | | |
| 17. Father's Name (First, Middle, Last)
<u>BENJAMIN JONES</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>CORA RUSSELL</u> | | 19a. Informant's Name/Relationship (Type, Print)
<u>ANNE JONES WIFE</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1647 N. APPLETON ST. BALTO. MD. 21217</u> | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>GARRISON FOREST</u> | | 20c. Location - City or Town, State
<u>8-29-00 OWINGS MILLS, MD</u> | | 21. Signature of Funeral Service Licensee
<u>Vaughn C. H.</u> | | |
| 22. Name and Address of Facility
<u>VAUGHN C. GREENE FUNERAL SERVICE</u>
<u>5151 BALD NATL PIKE, BALTO. MD. 21229</u> | | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. <u>Intracerebral hemorrhage</u>
Due to (or as a consequence of):

f.
Due to (or as a consequence of):

g.
Due to (or as a consequence of):

h.
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | |
| 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>Nirav Shah</u> | | |
| 29c. License number
<u>BU417643512457</u> | | 29d. Date signed (Month, Day, Year)
<u>8/24/00</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Nirav Shah University of Maryland Hospital 22 S. Greenestreet Baltimore Md 21201</u> | | 31. Date filed (Month, Day, Year)
<u>AUG 28 2000</u> | | |
| 32. Registrar's Signature
<u>B. Sparks</u> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27111

Amended Item #7 per FHG786 8/31/2000 EW

| | | | | | |
|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GENEVA JENKINS | | 2. Date of Death
Month August Day 27 Year 2000 | | 3. Time of Death
2:00 AM |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
246-22-5788 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
03-29-20 | | 9. Birthplace (State or Foreign Country)
NC | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
1737 Cliftview Avenue | | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th Grade College (1-4 or 5+) NA | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
Zenrite Company | | | |
| 17. Father's Name (First, Middle, Last)
Louis Evans | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Jones | | |
| 19a. Informant's Name/Relationship (Type, Print)
Virginia Prettlow | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1737 Cliftview Avenue Baltimore, MD. 21213 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. Nat'l Mem. Pk. Cem. 08-30-2000 Laurel, MD | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
H. Valencia Holland | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. SEPSIS
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
2 days | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. PNEUMONIA
Due to (or as a consequence of): | | 1 week | |
| | | c.
Due to (or as a consequence of): | | | |
| | | d.
Due to (or as a consequence of): | | | |
| | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
D. Dancy MD | | 29c. License number
P 11902 | | 29d. Date signed (Month, Day, Year)
August 27, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NOORAH DADAJ
GOOD SAMARITAN HOSPITAL
5601 LOCK RAVEN BLVD BALTIMORE MD 21237 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Geneva G Sparks | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27112

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DIANA V. JACKSON | | | | 2. Date of Death
Month Day Year
August 26, 2000 | | 3. Time of Death
2:30 A | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE Geriatric Center + Hospital | | | | 4b. City, Town, or Location of Death
BALTO | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-56-7455 | | 6. Sex
1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 Yrs. | | 8. Date of Birth (Month, Day, Year)
01-19-1951 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by
Funeral Director | Usual Residence of Decedent | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MEDICAL ASSISTANT | | 16b. Kind of Business/Industry
HEALTH | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
JAMES H. JACKSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PERNETTA BOYD | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
GLORIA ISHMEAL /SISTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6810 PARK HEIGHTS. AVENUE, BALTO., MD. 21215 | | | |
| To Be Completed by
Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING MEM PARK | | 20c. Location - City or Town, State
BALTO., MD. | |
| | 21. Signature of Funeral Service Licensee
James A. Morton | | | | 22. Name and Address of Facility
JAMES A. MORTON & SONS F.H., INC
1701 LAURENS ST. BALTO., MD. 21217 | | | |
| To Be Completed by
Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease yrs.
Due to (or as a consequence of):
b. Anoxic Encephalopathy
Due to (or as a consequence of):
c. Chronic Respiratory Failure
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by
Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by
Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by
Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Debra S. Wertheimer MD | | | |
| To Be Completed by
Physician/Medical Examiner | 29c. License number
D23767 | | | | 29d. Date signed (Month, Day, Year)
August 26, 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Debra S. Wertheimer MD 2434 W. Belvedere Rd, Balto, MD 21224 | | | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | |
| To Be Completed by
Physician/Medical Examiner | 32. Registrar's Signature
Jennifer B. Sparks | | | | 33. State Registrar
AUG 28 2000 | | | |

ORIGINAL

1000 7 1200

Don't be surprised if you find
the following in your
household.

1. *Phosphorus*
2. *Sulfur*
3. *Carbon*
4. *Iron*
5. *Copper*
6. *Lead*
7. *Mercury*
8. *Strontium*
9. *Barium*
10. *Calcium*
11. *Sodium*
12. *Potassium*
13. *Lithium*
14. *Ammonium*
15. *Magnesium*
16. *Zinc*
17. *Nickel*
18. *Cadmium*
19. *Cobalt*
20. *Chromium*
21. *Manganese*
22. *Vanadium*
23. *Titanium*
24. *Aluminum*
25. *Silicon*
26. *Boron*
27. *Fluorine*
28. *Bromine*
29. *Iodine*
30. *Chlorine*
31. *Oxygen*
32. *Nitrogen*
33. *Hydrogen*

It is not only the elements
themselves but also the
compounds of these elements
which are found in the
household.

For example, the
following are some of the
compounds which are found
in the household:

1. *Salt*
2. *Sugar*
3. *Starch*
4. *Fat*
5. *Protein*
6. *Vitamin*
7. *Mineral*
8. *Enzyme*
9. *Antibiotic*
10. *Antacid*
11. *Analgesic*
12. *Antipyretic*
13. *Antiseptic*
14. *Disinfectant*
15. *Deodorant*
16. *Perfume*
17. *Soap*
18. *Detergent*
19. *Paint*
20. *Ink*
21. *Paper*
22. *Plastic*
23. *Glass*
24. *Concrete*
25. *Brick*
26. *Stone*
27. *Wood*
28. *Leather*
29. *Textile*
30. *Food*
31. *Drink*
32. *Medicine*
33. *Chemical*
34. *Gas*
35. *Liquid*
36. *Solid*
37. *Plasma*
38. *Quartz*
39. *Diamond*
40. *Gemstone*
41. *Crystal*
42. *Mineral*
43. *Rock*
44. *Soil*
45. *Water*
46. *Air*
47. *Fire*
48. *Light*
49. *Sound*
50. *Heat*
51. *Electricity*
52. *Magnetism*
53. *Gravity*
54. *Pressure*
55. *Temperature*
56. *Humidity*
57. *Wind*
58. *Cloud*
59. *Rain*
60. *Snow*
61. *Hail*
62. *Fog*
63. *Mist*
64. *Dew*
65. *Frost*
66. *Sleet*
67. *Ice*
68. *Snowflake*
69. *Comet*
70. *Meteor*
71. *Star*
72. *Planet*
73. *Galaxy*
74. *Universe*
75. *Life*
76. *Death*
77. *Birth*
78. *Love*
79. *Hate*
80. *Hope*
81. *Despair*
82. *Joy*
83. *Sorrow*
84. *Anger*
85. *Peace*
86. *War*
87. *Friendship*
88. *Enmity*
89. *Kindness*
90. *Cruelty*
91. *Generosity*
92. *Stinginess*
93. *Humility*
94. *Pride*
95. *Modesty*
96. *Shame*
97. *Honor*
98. *Disgrace*
99. *Success*
100. *Failure*

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State of Maryland / Department of Health and Mental Hygiene

00 27113

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Roseline M. Korniewicz | | 2. Date of Death
Month August Day 26 Year 2000 | | 3. Time of Death
4:03 PM |
| | 4a. Facility Name (If not institution, give street and number)
1569 RED HAVEN DRIVE | | 4b. City, Town, or Location of Death
SEVERN | | 4c. County of Death
ANNE ARUNDEL |
| Funeral
Director | 5. Social Security Number
386-18-2183 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
JULY 27, 1924 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
SEVERN | |
| 10e. Street and Number
1569 RED HAVEN DRIVE | | 10f. Zip Code
21144 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BUS DRIVER | | 16b. Kind of Business/Industry
TRANSPORTATION | |
| 17. Father's Name (First, Middle, Last)
ANTHONY LUCZAK | | | 18. Mother's Name (First, Middle, Maiden Surname)
CATHERINE REDLESIK | | |
| 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER)
MRS. DENISE KORNIWICZ | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1569 RED HAVEN DRIVE, SEVERN, MARYLAND 21144 | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION CENTER, LLC | | 20c. Location - City or Town, State
STEVENSVILLE, MD. | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> MO1220 | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME, P.A.,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <i>Myocardial Infarction</i>
Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death
<i>1 hour</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. <i>Coronary Heart Disease</i>
Due to (or as a consequence of): | | | <i>10 years</i> |
| | | c. <i>Arteriosclerosis</i>
Due to (or as a consequence of): | | | |
| | | d. | | | |
| | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| <i>Diabetes mellitus</i> | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| <i>Renal Failure</i> | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| <i>Congestive Heart Failure</i> | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
H17744 | | 29d. Date signed (Month, Day, Year)
8/28/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID SCHWARTZ 300 Hospital Dr., Glen Burnie, Md 21061 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27114

| | | | | | | | | |
|---|---|---|---|--|---|--|----------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Dixie Marlene Kelley | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
1:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
513 N Marlyn Avenue | | | | 4b. City, Town, or Location of Death
Essex | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
217-34-6372 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct. 1, 1936 | | 9. Birthplace (State or Foreign Country)
Indiana |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
513 N. Marlyn Avenue | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Secretary | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Clerical | | |
| 17. Father's Name (First, Middle, Last)
James A. Kelley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruth M. Stoelting | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Trent Bowen (Brother in Law) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
930 Cromwell Bridge Road Baltimore, MD 21286 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Park | | Date
8/26/2000 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Metastatic ovarian Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D46118 | | 29d. Date signed (Month, Day, Year)
Aug 24 th , 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1447 YORK RD Lutherville MD 21093 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27115

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard James Kassolis | | | | 2. Date of Death
Month Day Year
August 25, 2000 | | 3. Time of Death
1:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris @ Mercy Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
223-18-7857 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
95 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1904 | |
| | 9. Birthplace (State or Foreign Country)
Turkey | | 10a. State
MD | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1190 West Northern Parkway Unit 920 | | 10f. Zip Code
21210 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self Employed | | 16b. Kind of Business/Industry
Heating & Air Conditioning | | | |
| | 17. Father's Name (First, Middle, Last)
James Kassolis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Aspasia Dukakis | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mr. Duke Kassolis/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Ivy Brook Farm Court Hunt Valley, MD 21030 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greek Orthodox Cemetery | | 20c. Location - City or Town, State
08/28/2000 Woodlawn, Maryland | | 21. Signature of Funeral Service Representative
Stephen D. Copster M001122 | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc
1050 York Road Towson, Maryland 21204 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Lung Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
DAVID RISEBERG | | | |
| | 29c. License number
D40854 | | | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202 | | | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | |
| | 32. Registrar's Signature
[Signature] | | | | 33. State Registrar
AUG 28 2000 | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27116

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph L. Kachinski, Sr. | | | | 2. Date of Death
Month Day Year
August 25, 2000 | | 3. Time of Death
6:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Lorien-Frankford Nursing Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
180-03-1347 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 19, 1918 | |
| | 9. Birthplace (State or Foreign Country)
PA | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3510 Glenarm Avenue | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dispatch Supervisor | | 16b. Kind of Business/Industry
Retail Department Store | | | |
| | 17. Father's Name (First, Middle, Last)
Frank Kuczynski | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances | | 19. Informant's Name/Relationship (Type, Print)
Jean D. Kachinski-Wife | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cemetery | | Date
8/29/00 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
William G. Dau | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Rd., Baltimore, MD 21214 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. <u>Emphysema</u>
Due to (or as a consequence of):
b. <u>metastatic cell lymphoma</u>
Due to (or as a consequence of):
c. <u>parapneumonia</u>
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
Daw | | 29c. License number
D 31464 | | 29d. Date signed (Month, Day, Year)
8/29/00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHARIS A HARRIS, 821 N. Eutam St Suite 308, Balt. MD 21201 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Benjamin S. Sparks | | | | | |
| | 33. State Registrar
1041 | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27117

| | | | | | | | |
|--|--|---|---|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SARAH TRANTER KAUFMANN | | | 2. Date of Death
Month Day Year
AUGUST 23, 2000 | | 3. Time of Death
10:40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
11324 PARK HEIGHTS AVENUE | | | 4b. City, Town, or Location of Death
OWINGS MILLS | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
196-12-0717 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
NOV. 8, 1924 | 9. Birthplace (State or Foreign Country)
PA |
| | Usual Residence of Decedent | | | | | | |
| 10e. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
OWINGS MILLS | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
11324 PARK HEIGHTS AVENUE | | | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| 17. Father's Name (First, Middle, Last)
GEORGE TRANTER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JANE BUCHANAN | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LOUISE MELEDIN / ATTORNEY | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
406 BOSLEY AVENUE - TOWSON, MD 21204 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HILLTOP SERVICE CORP. | | Date
8/25/00 | | 20c. Location - City or Town, State
TOWSON, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Inflammatory Demyelinating Polyneuropathy ~ 9 months
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D47373 | | 29d. Date signed (Month, Day, Year)
8/24/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID MCGINNIS, MD 10753 Falls Road #225 Lutherville MD 21093 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
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ORIGINAL

Chronic inflammation of the lungs

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Carol Bear Kleinman

State of Maryland / Department of Health and Mental Hygiene

00 27118

AMENDED# 27, 28 per ME G793 031901 SS

PER MFO G787 9-14-00 WR

AMEND ITEMS: #23 PART I, 27, 28A-F

Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|---|---|--|--------------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CAROL B KLEINMAN | | | 2. Date of Death
Month August Day 24 Year 2000 | | 3. Time of Death
1115 am | |
| | 4a. Facility Name (If not institution, give street and number)
Saint Thomas Lane at Reisterstown Road | | | 4b. City, Town, or Location of Death
Owings Mill | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-54-2977 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
50 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 14, 1949 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
6707 WESTERN RUN DRIVE | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MORTGAGE BANKER | | | 16b. Kind of Business/Industry
FINANCE | |
| 17. Father's Name (First, Middle, Last)
HARRY BEAR | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SYLVIA WILSON | | | |
| 19a. Informant's Name/Relationship (Type, Print)
HOWARD KLEINMAN / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6707 WESTERN RUN DRIVE - BALTIMORE, MD 21215 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHIZUK AMUNO ARLINGTON | | Date
8/25/00 | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
DROWNING

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
COMBINED DRUG AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
8-24-00 | | 28b. Time of Injury
11:15 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
SUBJECT INGESTED DRUGS, COLLAPSED & DROWN - unknown | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
STREAM | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
NR. REISTERSTOWN RD. OWINGS MILL, MD. | | | | | | | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SMIALEK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27119

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eva M. Leash

2. Date of Death

Month
AugDay
18Year
2000

3. Time of Death

2056

4a. Facility Name (If not institution, give street and number)

ST. AGNES HEALTHCARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

Funeral
Director

5. Social Security Number

214-44-3008

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug 6, 1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

411 S. Furrow Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unkCollege (1-4 or 5+)
unk16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

disabled

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Saint Agnes Healthcare

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 S. Caton Avenue Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

HEART FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Unknown

b.

AORTIC STENOSIS

Due to (or as a consequence of):

Unknown

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

A. FIBRILLATION

CHRONIC OBSTRUCTIVE PULMONARY
DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P-13592

29d. Date signed (Month, Day, Year)

Aug 18, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME
LEASH, EVA M

Division of Vital Records, P.O. Box 68760,

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

EARL N. LESTER

State of Maryland / Department of Health and Mental Hygiene

00 27120

amend item 20b,c,per fh G787 9/26/00 yf

amend item 23a,27,28a,b,c,d,e,f,per me G787 9/26/00 yf

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EARL NATHANIEL LUSTER | | | | 2. Date of Death
Month Day Year
AUG. 26, 2000 | | 3. Time of Death
0839 AM | |
| | 4a. Facility Name (If not institution, give street and number)
942 BENNETT PLACE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-56-9820 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 26, 1952 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
76 S. KOSSUTH STREET | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
USA. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12TH GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TRUCK DRIVER | | 16b. Kind of Business/Industry
SELF-EMPLOYED | | | |
| | 17. Father's Name (First, Middle, Last)
LEON | | 18. Mother's Name (First, Middle, Maiden Surname)
DOROTHY JACKSON | | 19a. Informant's Name/Relationship (Type, Print)
DOROTHY LUSTER (MOTHER) | | | |
| Physician
/Medical
Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
76 S. KOSSUTH ST., BALTIMORE, MD. 21229 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. Location - City or Town, State
LANSLOWNE, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTO. MD. 21217 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ACUTE ETHANOL, COCAINE AND NARCOTIC INTOXICATION | | | | | | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Division of Vital Records, P.O. Box 68760, | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | 27d. Describe how injury occurred
unknown |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28a. Date of Injury (Month, Day, Year)
found: 8/26/00 | | | | | | | 28b. Time of Injury
found: 8:30 A M |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Location (Street and Number or Rural Route Number, City or Town, State)
942 Bennett Place Baltimore, Maryland | | | | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
942 Bennett Place Baltimore, Maryland |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | | | | 29c. License number
O.C.M.E |
| | 29d. Date signed (Month, Day, Year)
AUG. 27, 2000 | | | | | | | |
| DHHM 16 Rev 6/95 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute
111 Penn Street, Baltimore, Maryland 21201 | | | | | | | 32. Registrar's Signature
<i>[Signature]</i> |
| | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 27121**
Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bernie Lee | | 2. Date of Death
Month August Day 21 Year 2000 | | 3. Time of Death
7:07 p.m. |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
242-30-4407 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months 0 Days 0 | If Under 24 Hrs.
Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year)
7/13/16 | | 9. Birthplace (State or Foreign Country)
N.C. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
City | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
124 W. Franklin St. | | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Janitor | | 16b. Kind of Business/Industry
State Of Maryland | |
| 17. Father's Name (First, Middle, Last)
Bud Lee | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Lee | | |
| 19a. Informant's Name/Relationship (Type, Print)
Annie M. Wicks Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2728 Guilford Ave, Baltimore, Md. 21218-4415 | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | 20c. Location - City or Town, State
8/23/00 Catonsville, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Estep Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Overwhelming Sepsis
Due to (or as a consequence of):
b. Respiratory Failure
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
89379 | | 29d. Date signed (Month, Day, Year)
8/21/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shivani Negi, M.D. c/o Maryland General Hospital | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-698-2000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27122

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rose Katherine Liberto | | | | 2. Date of Death
Month Day Year
August 23 2000 | | 3. Time of Death
7:00AM | |
| | 4a. Facility Name (If not Institution, give street and number)
10 Acorn Circle #202 | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-14-0517 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 28 1917 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Baltimore | 10c. City, Town or Location
Towson | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
10 Acorn Circle #202 | | | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Saverio Curreri | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarafina Garbo | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mr. Carmen Liberto/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Acorn Circle #202 Towson, Md. 21204 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gdns. | | 20c. Date
8-26-00 | | 20d. Location - City or Town, State
Timonium, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility (Give kind of work done during most of working life. DO NOT use retired)
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Myocardial infarction
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
12 hr.
15 hr. |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypocalcemia, Anemia | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D22409 | | 29d. Date signed (Month, Day, Year)
8/25/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph D. Antonio, M.D. 7401 Oak Drive Suite 110 Towson, Md. 21204 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | |

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27123

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|--------------------------------------|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RICHARD C. MILLER | | | | 2. Date of Death
Month Day Year
AUGUST 11, 2000 | | | | 3. Time of Death
8:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
150 Spring Side Drive | | | | 4b. City, Town, or Location of Death
Timonium | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
044-28-8611 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 31, 1939 | | 9. Birthplace (State or Foreign Country)
CT | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Timonium | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
150 Spring Side Drive | | | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: '56-59 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk College (1-4 or 5+) unk | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
systems engineer | | | 16b. Kind of Business/Industry
unk | | |
| | 17. Father's Name (First, Middle, Last)
unk | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith Mitchell | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
unk | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unk | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer with Brain Metastasis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
W. J. | | | | 29c. License number
D32543 | | | 29d. Date signed (Month, Day, Year)
8/11/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARK STROMBORG 6701 N. Charles St. Baltimore MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

00-4538-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

GORDON

State of Maryland / Department of Health and Mental Hygiene

00 27124

MURPHY

AMEND ITEMS: #23 PART I, 27

PER MEO G786 8-29-00 WR.

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--------------------------------------|---|--|--|--|--|--|-------------------------------------|--|--|--|--|-------------------------------------|--|--|--|--|-------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GORDON MURPHY | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
5:03P.M. | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
MERCY HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
UNK | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | | | | | | | | | | | | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year)
Aug 4, 1934 | | 9. Birthplace (State or Foreign Country)
USA | | | | | | | | | | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
unk | | 10b. County
unk | | 10c. City, Town or Location
unk | | | | | | | | | | | | | | | | | | | | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
unk | | | 10f. Zip Code
unk | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
unk
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk
College (1-4 or 5+) unk | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unk | | 16b. Kind of Business/Industry
unk | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
unk | | | 18. Mother's Name (First, Middle, Maiden Summa)
unk | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Pwnn Street Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Date | | 20c. Location - City or Town, State | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td colspan="5"> a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
 Due to (or as a consequence of): </td> </tr> <tr> <td colspan="5">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="5">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="5">d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of): | | | | | b. Due to (or as a consequence of): | | | | | c. Due to (or as a consequence of): | | | | | d. Due to (or as a consequence of): | | | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | | | | | | | | | | | | | | | | | | | | | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Stephen S. Radentz, M.D. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27125

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Lisch, Milton</i> | | | | 2. Date of Death
Month <i>7</i> Day <i>22</i> Year <i>2000</i> | | 3. Time of Death
<i>11:00</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>UNLV MD Medcenter</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>248-12-9545</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>82</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>FEB 11 1918</i> | 9. Birthplace (State or Foreign Country)
<i>S.C.</i> | | | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
<i>5311 GIST AVE.</i> | | | | 10f. Zip Code
<i>21215</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8th</i> College (1-4or 5+) <i>NA</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>CONSTRUCTION WORKER</i> | | 16b. Kind of Business/Industry
<i>CONSTRUCTION</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>ED MEITON</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>LEOLA WELLS</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>EDNA RAYMOND-DAUGHTER</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5311 GIST AVE. BALTO. MD 21215</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>KING MEM. PARK</i> | | 20c. Date
<i>8-29-00</i> | | 20d. Location - City or Town, State
<i>Randallstown Md</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Wheeler Edmund</i> | | | | 22. Name and Address of Facility
<i>MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE BALTO MD 21215</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. <u>KNOXIC BRAIN ANEURYSM</u></i>
Due to (or as a consequence of):
<i>b. <u>PULMONARY EDEMA</u></i>
Due to (or as a consequence of):
<i>c. <u>LIVER CIRRHOSIS</u></i>
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>d.</i> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>James W. MD PhD</i> | | | | 29c. License number
<i>13116</i> | | 29d. Date signed (Month, Day, Year)
<i>8/22/00</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>UNLV MD MED CENTER 22 S. GREENE ST, BALTIMORE, MARYLAND 21201</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 28 2000</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27126
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|--|---|--|--|---|---|--|--|---------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES EDWARD MOODY JR. | | | | 2. Date of Death
Month Day Year
AUGUST 22 2000 | | 3. Time of Death
8:30 AM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
HARFORD MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
HAVRE DE GRACE | | 4c. County of Death
HARFORD | | | | | | |
| Funeral
Director | 5. Social Security Number
213-64-0201 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
46 Yrs. | | 8. Date of Birth (Month, Day, Year)
11-26-1953 | | 9. Birthplace (State or Foreign Country)
MD | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
MD | | | 10b. County
Anne Arundel | | | 10c. City, Town or Location
Glen Burnie | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
207 Foxridge Court | | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
U.S.A | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | | 16b. Kind of Business/Industry
Transportation | | | | | |
| 17. Father's Name (First, Middle, Last)
Charles Moody Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emily Wallace | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gloria Moody/ Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
207 Foxridge Court Glen Burnie MD 21061 | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park | | | Date
Aug 26-2000 | | 20c. Location - City or Town, State
Glen Burnie, MD | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Singleton Funeral Home P.A.
1 Second Ave. S.W. Glen Burnie MD 21061 | | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Multiple Injuries
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year)
8/22/00 | | 28b. Time of Injury
0432 M | | 28c. Injury at Work?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred
Driver in vehicle collision | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
STREET | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
I-95 South, marker 85.3 | | | | | | | |
| 29a. Certify (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 23, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JULIAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27127

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN GRETA CORPREW MOORMAN

2. Date of Death

8/12/2000

3. Time of Death

4:28 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6/25/31

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3139 SEQUOIA AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

LUCAS CORPREW

18. Mother's Name (First, Middle, Maiden Surname)

GOLDIE CORPREW

19a. Informant's Name/Relationship (Type, Print)

HENRY P. MOORMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3139 SEQUOIA AVE. BALTO. MD. 21215

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY 8/23/2000 CATONSVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Kashyap 2401 West Belvedere Avenue Baltimore, Maryland 21215

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27128

| | | | | | | | | |
|---|---|---|---|--|--|--|---------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY LYNN MAINHART | | | | 2. Date of Death
Month: AUGUST Day: 24 Year: 2000 | | 3. Time of Death
04:40 | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL OF BALTIMORE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE CITY | |
| Funeral
Director | 5. Social Security Number
101-38-3538 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 21, 1946 | | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10a. Street and Number
152 HAMMARLEE RD., APT. G | | | | 10f. Zip Code
21060 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PATIENT REPRESENTATIVE | | 16b. Kind of Business/Industry
MEDICAL | | |
| 17. Father's Name (First, Middle, Last)
ARTHUR R. PRICE, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
G. EVELYN FOLEY | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
KENNIETH N. MAINHART / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
152 HAMMARLEE RD., APT. G, GLEN BURNIE, MD 21060 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GLEN HAVEN MEM. PK. | | Date
AUG. 28 2000 | | 20c. Location - City or Town, State
GLEN BURNIE, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. SEPSIS
Due to (or as a consequence of): | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. RENAL FAILURE
Due to (or as a consequence of): | | | | | | |
| | | c. RETROPERITONEAL SARCOMA
Due to (or as a consequence of): | | | | | | |
| | | d. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC MYELOGENOUS LEUKEMIA, DIABETES MELLITUS,
ATRIAL FIBRILLATION, HYPERTENSION | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
19678 | | 29d. Date signed (Month, Day, Year)
AUGUST 24, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KRISTIN E. ERICKSON, MD 2401 W. BELVEDERE, BALTIMORE, MD 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27129

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pamela Moreen Norman

2. Date of Death

Month

Day

Year

3. Time of Death

August 25 2000 3:38 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-32-7297

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 29, 1930

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1617 Turkey Point Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frederick Basher

18. Mother's Name (First, Middle, Maiden Surname)

Olive Sellick

19a. Informant's Name/Relationship (Type, Print)

James Norman (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1617 Turkey Point Road, Essex, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens 8/29/2000 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Brain Injury

Due to (or as a consequence of):

b. Seizures

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arbi Ghazarian MD, 9000 Franklin Square Drive, Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Norman, Pamela
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27130

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucile F. Otton

2. Date of Death

August 24, 2000

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

318-18-6827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/18/1917

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane T09 Brookside

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Hugo William Fredigke

18. Mother's Name (First, Middle, Maiden Surname)

Helen Scott Richardson

19a. Informant's Name/Relationship (Type, Print)

Edmond G. Otton - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 Maiden Choice Lane T09, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crest Lawn Memorial

Date

8/29/00

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensed

Michael N. Vekula

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Matthew J. Narek M.D.

29c. License number

D44748

29d. Date signed (Month, Day, Year)

August 25, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MATTHEW J. NAREK 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Benjamin A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27131

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Reynaldo Tiburcio Ocampo | | | | 2. Date of Death
Month AUGUST Day 25 Year 2000 | | 3. Time of Death
7:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
ROSEDALE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
217-70-0368 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 11, 1916 | |
| | 9. Birthplace (State or Foreign Country)
Philippines | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1 Brett Court | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U. S. A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Asian | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Tailor | | 16b. Kind of Business/Industry
Clothing | | | | |
| 17. Father's Name (First, Middle, Last)
Leoncio Ocampo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Feliza Pascual | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Armando de Guzman Ocampo (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5613 Jarist Drive Clifton, Virginia 20124 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Gard. | | 20c. Location - City or Town, State
2000 Dulaney Valley, MD | | | | |
| 21. Signature of Funeral Service Licensee
<i>Michael C. Saffian</i> | | | | 22. Name and Address of Facility
Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY FIBROSIS
Due to (or as a consequence of):
3 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Stuart Acherman D.O.</i> | | | | 29c. License number
RD 198796 | | 29d. Date signed (Month, Day, Year)
8/25/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27132

amend item 24a 4a per phys. G787 9/5/00 yf

EDWARD E. RICH 530 26 AUG-UST 2000

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

YR

| | | | | | | | | |
|--|---|--|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward Rich | | | | 2. Date of Death
Month Day Year
Aug. 26, 2000 | | 3. Time of Death
5:30am | |
| | 4a. Facility Name (If not institution, give street and number)
Gift of Hope Home 818 N. Cillington Ave. Balto., MD
Gift of Hope Hospice | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
227-56-0780 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
03-08-43 | | 9. Birthplace (State or Foreign Country)
VA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
816 McAleer Court | | | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd. Grade
College (1-4 or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Construction worker | | 16b. Kind of Business/Industry
Construction Co., | | |
| 17. Father's Name (First, Middle, Last)
Thomas Rich | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Thompson | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Brenda Rich | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202
816 McAleer Court Baltimore, Maryland | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cemetery | | Date
08-28-2000 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Bladys Wane | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
AIDS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Lymphoma
Herpes zoster | | | | | | | | Approximate interval Between Onset and Death
>1 yr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Lymphoma
Herpes zoster | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
John N. Payne M.D. | | 29c. License number
00013012 | | 29d. Date signed (Month, Day, Year)
26 Aug 00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Payne 4505 N. Charles St., 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
James B. Spotts | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27133

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LESTER LEE RICE, SR

2. Date of Death

Month Day Year
August 26, 2000

3. Time of Death

12:57 P.M.

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

251-19-7515

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6-29-58

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2927 EDGEcombe CIRCLE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 82-8413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

AIR CONDITION/REFRIG.

17. Father's Name (First, Middle, Last)

LUCIAN RICE

18. Mother's Name (First, Middle, Maiden Surname)

EVA CANTEEN

19a. Informant's Name/Relationship (Type, Print)

MICHELLE RICE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2927 EDGEcombe CIR., BALTO., MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HOPEWELL CEMETERY

Date

9/2/2000 GEORGETOWN, S.C.

21. Signature of Funeral Service Licensee

James G. Morton

22. Name and Address of Facility

JAMES A. MORTON & SONS F.H., INC
1701 LAURENS ST., BALTO., MD. 2121723a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cardiac Arrhythmia

a.

Due to (or as a consequence of):

Electrolyte Imbalance in Association with Hepato-Duodenal Fungal Abscess

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Lobar Pneumonia; Acute and Chronic Pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending
investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mary E. Ripple, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY E. RIPLE, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

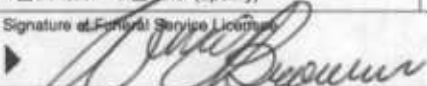
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

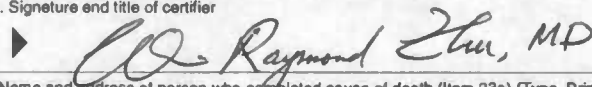
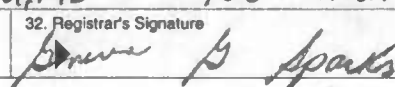
Certificate of Death

Reg. No.

00 27134

| | | | | | | | | | |
|--|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAURICE ROBINSON | | | | 2. Date of Death
Month 8 Day 24 Year 2000 | | 3. Time of Death
7:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
St. AGNES HEALTHCARE, 900 CATON AVE. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE. | | |
| Funeral
Director | 5. Social Security Number
212-11-9765 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
28 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV 27 1971 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10. Usual Residence of Decedent
10a. State MARYLAND 10b. County N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number
2845 HINSDALE DRIVE | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TRUCK DRIVER | | 16b. Kind of Business/Industry
TRANSPORTATION | | | | |
| | 17. Father's Name (First, Middle, Last)
MAURICE ROBINSON, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DATRICIA WILSON | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Alva J. Robinson/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2845 Hinsdale Drive., Baltimore, Maryland 21230 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEMETERY | | 20c. Date
8-30-00 | | 20d. Location - City or Town, State
BALTIMORE, MARYLAND | | |
| | 21. Signature of Funeral Service Licentiate
 | | | | 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Pulmonary hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
5 hours
1 month
2 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier

W. RAYMOND ZHU, MD | | 29c. License number
D0056143 | | 29d. Date signed (Month, Day, Year)
8/25/2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. RAYMOND ZHU, MD 900 CATON AVENUE, BALTIMORE, MD 21229 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27135

| | | | | | |
|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
STEVEN ROTH | | 2. Date of Death
Month Day Year
AUGUST 23, 2000 | | 3. Time of Death
4:40 PM |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
131-36-7127 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
JUL.30,1947 | | 9. Birthplace (State or Foreign Country)
HAWAII | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
HOWARD | | 10c. City, Town or Location
COLUMBIA | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
5511 VANTAGE POINT ROAD | | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: VIETNAM | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CRIMINAL INVESTIGATOR | | 16b. Kind of Business/Industry
LAW | |
| 17. Father's Name (First, Middle, Last)
GEORGE ROTH | | | 18. Mother's Name (First, Middle, Maiden Surname)
RUTH MICHAELS | | |
| 19a. Informant's Name/Relationship (Type, Print)
GAIL ROTH / WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5511 VANTAGE POINT ROAD - COLUMBIA, MD 21044 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH EL MEMORIAL PARK | | 20c. Location - City or Town, State
8/25/00 RANDALLSTOWN, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. LIVER FAILURE | | | Approximate Interval Between Onset and Death
2 WEEKS |
| Due to (or as a consequence of): | | b. PORTAL VEIN THROMBOSIS | | | 3 WEEKS |
| Due to (or as a consequence of): | | c. HEPATOCELLULAR CARCINOMA | | | 6 MONTH |
| Due to (or as a consequence of): | | d. CHRONIC HEPATITIS C | | | 12 YR |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury et Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D31207 | | 29d. Date signed (Month, Day, Year)
8/24/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID SALTZBERG MD 6665 N. CHARLES ST (612) TOWSON MD 21204 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27136

| | | | | | | | | | | | |
|---|--|---|---|--|---|--|--|--------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Sarah Faile Sanderson | | | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | 3. Time of Death
10:43 P.M. | | |
| | 4e. Facility Name (If not institution, give street and number)
FREDERICK MEMORIAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death
FREDERICK | | 4c. County of Death
FREDERICK | | |
| Funeral
Director | 5. Social Security Number
247-32-1555 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 8. Date of Birth
(Month, Day, Year)
Oct 8, 1925 | | 9. Birthplace (State or Foreign Country)
DC | | 10a. State
MD | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1421 Taney Avenue #324 | | 10f. Zip Code
21702 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
bookkeeper | | 16b. Kind of Business/Industry
unk | | | | | | |
| | 17. Father's Name (First, Middle, Last)
George F. Faile | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mitchell Catoe | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Frederick Memorial Hospital | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Park Place & W. 7th St Frederick, MD 21702 | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Pneumonia</u>
Due to (or as a consequence of):
b. <u>Coronary opathy</u>
Due to (or as a consequence of):
c. <u>NIDDM</u>
Due to (or as a consequence of):
d. <u>Chronic Renal Insufficiency</u> | | Approximate Interval Between Onset and Death
3 days | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Renal Cell Carcinoma</u> <u>LV Thrombus</u>
<u>CHF</u> <u>Previous MI x4</u>
<u>HTN</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Michael Casagrande MD | | 29c. License number
D0053224 | | 29d. Date signed (Month, Day, Year)
8/23/00 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1564 Opossumtowns Pike Frederick MD 21701 Michael Casagrande | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Benita B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27137

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THANEUS SKEEN | | | | 2. Date of Death
Month Day Year
AUGUST 20, 2000 | | 3. Time of Death
2056 PM | |
| | 4a. Facility Name (If not institution, give street and number)
MARYLAND GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
238-50-9605 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 12, 1939 | |
| | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
1738 Diamond Street | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk College (1-4 or 5+) unk | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unk | | 16b. Kind of Business/Industry
unk | |
| | 17. Father's Name (First, Middle, Last)
unk | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unk | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Maryland General Hospital | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
827 Linden Avenue Baltimore, MD 21201 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
INSPECTION
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
Stephen S. Radentz, M.D. | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
AUGUST 21, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27138

| | | | | | | | | | |
|--|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY L. SPRATLEY | | | | 2. Date of Death
Month August Day 22 Year 2000 | | 3. Time of Death
12:35 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | | |
| Funeral
Director | 5. Social Security Number
231-22-0619 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3-16-1927 | | 9. Birthplace (State or Foreign Country)
S.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
4002 Rosecroft | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Health Assistance | | 16b. Kind of Business/Industry
Rosewood State Hospital | | | |
| 17. Father's Name (First, Middle, Last)
Henry Kennedy | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Dicky | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gretchen L. Spratley Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4002 Rosecroft Avenue Balto, MD 21215 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cem. | | 20c. Location - City or Town, State
8-30-00 Pikesville MD | | | |
| 21. Signature of Funeral Service Licensee
William Edmund | | | | 22. Name and Address of Facility
Marchmont West 4300 Wabash Avenue Balto, MD 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. End stage Renal Disease
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | Approximate Interval Between Onset and Death
1 Day | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End stage Renal Disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier
Helen Z. Norwood, M.D. | |
| 29c. License number
RES 000 | | | | 29d. Date signed (Month, Day, Year)
August 22, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen Z. Norwood, M.D. 2401 West Belvedere Avenue, Baltimore MD 21215 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show important: if item 27 is marked other than "natural", the Medical Examiner must be notified at once. Spratley, Mary L.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27139

AMEND#16B PER F.H. G786 8-28-2000 JAB

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCIS SMITH | | | | 2. Date of Death
Month AUGUST Day 21st Year 2000 | | 3. Time of Death
4:46 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER. | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN. | | 4c. County of Death
BALTIMORE. | |
| Funeral
Director | 5. Social Security Number
218-10-2933 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 16, 1909 | 9. Birthplace (State or Foreign Country)
Jamaica |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Woodlawn | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
34 Torlina Ct. | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: African American | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef Cook | | 16b. Kind of Business/Industry
MERCHANT MARINES
Merchant Marie | | | |
| | 17. Father's Name (First, Middle, Last)
Alexander Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Adeline Cato | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Eva Smith (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
34 Torlina Ct. Woodlawn, Md. 21207 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest | | Date
9/5/2000 | | 20c. Location - City or Town, State
Owings Mills, Md. | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave Balto. Md. 21216 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. ACUTE MYOCARDIAL INFARCTION.
Due to (or as a consequence of): | | | | | | | |
| | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA. | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Dr. M. H. Sparks | | | |
| State Registrar | 29c. License number
D42723 | | | | 29d. Date signed (Month, Day, Year)
AUGUST 21st 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
AVVERAHALLI M HARISH.
RANDALLSTOWN MD 21133. | | | | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | |
| 32. Registrar's Signature
Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

00 27140

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27141

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Travis Edward Sharp | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | | | 3. Time of Death
10:20 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Harbor Hospital Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
214-02-3211 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
25 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 22, 1975 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | 10a. State
Maryland | | | | 10b. County
Harford | | 10c. City, Town or Location
Edgewood | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
1307 Clover Valley Way Apt G. | | | | 10f. Zip Code
21040 | | 10g. Citizen of What Country?
U. S. A. | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Iron Worker / Welder | | 16b. Kind of Business/Industry
Steel / Construction | | | | |
| 17. Father's Name (First, Middle, Last)
Edgar Edward Sharp | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jacqueline Mary Fisher | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edgar Edward Sharp (Father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4644 Muddy Creek Road Harwood, Maryland 20776 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
<i>Michael C. Zafra</i> | | | | 22. Name and Address of Facility
Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221 | | | | | | |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
08-23-2000 | | 28b. Time of Injury
9:44 A M | | 28c. Injury at Work?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Construction Site | | 28d. Describe how injury occurred
fell at construction site | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
801 International Drive, Linthicum, Maryland | | | | | | | | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dennis J. Chute</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 24, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
<i>Dennis J. Chute</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27142

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Dewey Spencer, Jr.

2. Date of Death

Month

Day

Year

August 24, 2000

3. Time of Death

1:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

216-18-0044

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

July 22, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2809 Wells Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Shipping Dept.

Steel Industry

17. Father's Name (First, Middle, Last)

David D. Spencer, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Estella Roberts

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Gladys W. Spencer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2809 Wells Road, Edgemere, Maryland 21219

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Gdns. 8/28/2000

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia, History of Central Venous Pressure

Hypertension, Coronary Artery Disease, Atrial Fibrillation

Previous myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD 192690

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Cole, MD. 9000 Franklin Square Drive, Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Spencer, David

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27143

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Peter Paul Stishan | | | | 2. Date of Death
Month Day Year
August 22, 2000 | | | | 3. Time of Death
4:12 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore County | | |
| Funeral
Director | 5. Social Security Number
205-22-1158 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 27, 1923 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
8212 Northview Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 Years
College (1-4 or 5+) 5+ | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Driver | | 16b. Kind of Business/Industry
Anchor Motor Freight | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Stishan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Tacianna Szewczyk | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Lona B. Stishan (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8212 Northview Road Dundalk, Maryland 21222 | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. | | 20c. Date
8/25/2000 | | 20d. Location - City or Town, State
Baltimore, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Dei C. Canell</i> | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Due to (or as a consequence of):
Pancreatic Cancer
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Tim</i> | | | | 29c. License number
D43725 | | | | 29d. Date signed (Month, Day, Year)
8/23/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TARIQ MAHMOOD 201-109 Back River Neck Road Baltimore MD 21221. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
<i>Sparks</i> | | | | | | | | | |

ORIGINAL

Printed in U.S.A.

5010-108-01

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27144

| | | | | | |
|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN SIMMONS | | 2. Date of Death
Month August Day 26 Year 2000 | | 3. Time of Death
3:25 AM |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
577-20-6560 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Aug. 13, 1921 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | |
| Usual Residence of Decedent | | | | | |
| 10e. State
MD | | 10b. County
-- | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
2809 Ailsa Avenue | | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own home | |
| 17. Father's Name (First, Middle, Last)
Charles H. Shaffer | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothea Fox | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carol Sattler- Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2809 Ailsa Ave., Baltimore, MD 21214 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery | | 20c. Location - City or Town, State
9/6/00 Arlington, VA | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Rd., Baltimore, MD 21214 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC SHOCK
Due to (or as a consequence of):
b. ISCHEMIC BOWEL
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPER TENSION
ATRIAL FIBRILLATION | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
P 12555 | | 29d. Date signed (Month, Day, Year)
AUGUST, 26, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMIN ALTANA, M.D. 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239 - 2995 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-0025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27145

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARJORIE E. SHIFFLER | | | | 2. Date of Death
Month Day Year
August 26 2000 | | 3. Time of Death
7-40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLENBURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
242-28-0210 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT. 22, 1920 | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1827 NORFOLK ROAD | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last)
RAFFIE CLEMENT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MINA AYERS | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
JANET SHIFFLER/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1323 HOLT CT. SYKESVILLE, MD 21784 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | Date
AUGUST 28, 2000 | | 20c. Location - City or Town, State
CATONSVILLE, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Kirkley-Ruddick Funeral Home P.A.
421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 | | | | 22. Name and Address of Facility | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
ACUTE RENAL FAILURE
Due to (or as a consequence of):
CHRONIC COAGULOPATHY
Due to (or as a consequence of):
CARDIOMYOPATHY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
2 weeks
3 MONTHS
2 YEARS | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
M. Shirazi, M.D. | | 29c. License number
D 46962 | | 29d. Date signed (Month, Day, Year)
AUGUST 26, 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061. | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
B. Spack | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27146

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RANDOLPH SCOTT | | | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
5:55 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-74-1763 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN 22 1958 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
1819 DIVISION STREET | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABORER | | 16b. Kind of Business/Industry
HANDYMAN | | 17. Father's Name (First, Middle, Last)
JAMES SCOTT | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
SARAH BENJAMIN | | 19a. Informant's Name/Relationship (Type, Print)
Sarah R. Benjamin/Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1819 Division Street, Baltimore, Maryland 21217 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT ZION CEMTERY | | 20c. Date
8-29-00 | | 20d. Location - City or Town, State
BALTIMORE, MARYLAND | | 21. Signature of Funeral Service Licensee
 | |
| | 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Sepsis | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| State Registrar | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Edgar Henriquez M.D. | | 29c. License number
89374 | | 29d. Date signed (Month, Day, Year)
8/25/00 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edgar Henriquez M.D. to Maryland General Hospital | | 31. Date (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
Jennifer Sparks | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27117

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn Thigpen

2. Date of Death

August 24 2000

3. Time of Death

2:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Frankford Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

224-66-7612

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02-21-49

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2804 Ashland Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th Grade

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Dietian

16b. Kind of Business/Industry

G.B.M.C.

17. Father's Name (First, Middle, Last)

Jesse C. Reed

18. Mother's Name (First, Middle, Maiden Summa)

Lillie Wood

19a. Informant's Name/Relationship (Type, Print)

Harvey Lee Reed

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2408 Lawn Wood Circle Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Pk. Cem. 08-28-2000 Randallstown, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ Gladys Wane

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SCLEROTERMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

ILRUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Matthew McNamey

29c. License number

045757

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MCNAMEY 5505 HOPKINS BAYVIEW RD. BAL 21224

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Benita B. Spotts

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27148

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy V. Trueheart

2. Date of Death

Month Day Year
Aug. 25, 2000

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-14-7264

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 10, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2954 Box Hill Court

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Russell Smith

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Mae Martin

19a. Informant's Name/Relationship (Type, Print)

Mrs. Linda Steiner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15801 Ensor Mill Road Sparks, Maryland 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cemetery

Date

8/28/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael J. Rudy

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/25/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Tariq Mahmood

ORIGINAL

AUGUST 25, 2000 3:50 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.DOROTHY TRUEHEART
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27149

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Catherine Mary Thiess | | | | 2. Date of Death
Month Day Year
August 23 2000 | | 3. Time of Death
12:16AM | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-01-3073 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 17 1920 | | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Rosedale | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
7310 Heinle Avenue | | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 | | College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
James O'Connor | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Dolan | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lorraine Flowers/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1556 Dellsway Road Baltimore, MD 21286 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Faith Cem. | | Date
8-26-00 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Cvach/Rosedale Funeral Home
1211 Chesaco Avenue, Baltimore, MD 21237 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
22 Hours | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular Accident | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D47350 | | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Ivan BORRELLO 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27150

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PAULINE M. WRIGHT | | | | 2. Date of Death
Month Day Year
08-25-2000 | | 3. Time of Death
5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
531 NEW PITTSBURG AVENUE | | | | 4b. City, Town, or Location of Death
TURNERS STATION | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
220-12-7778 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
12-24-1920 | |
| | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TURNERS STATION | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
531 NEW PITTSBURG AVENUE | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOMESTIC | | 16b. Kind of Business/Industry
HOME | | |
| 17. Father's Name (First, Middle, Last)
FRANK WILLIAMSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LUCINDA SIMMS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MARGARET MCCORD/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
531 NEW PITTSBURG AVE. BALTO., MD. 21222 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | Date
8/30/2000 | | 20c. Location - City or Town, State
BALTO., MD. | | |
| 21. Signature of Funeral Service Licensee
<i>James A. Morton</i> | | | | 22. Name and Address of Facility
JAMES A. MORTON & SONS F.H., INC
1701 LAURENS ST. BALTO., MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Endometrial carcinoma
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
2 yrs. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Michael McCollum</i> | | | | | | |
| | | 29c. License number
D41490 | | 29d. Date signed (Month, Day, Year)
Aug 28, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
9105 Franklin Square Dr. Balt. MD 21237 | | | | | | | | 31. Date filed (Month, Day, Year)
AUG 28 2000 |
| 32. Registrar's Signature
<i>Sparks</i> | | | | | | | | 33. Registrar's Name
Michael McCollum, MD |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27151

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ERNEST F WILSON | | | | 2. Date of Death
Month Day Year
AUGUST 23 2000 | | 3. Time of Death
9:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
BON SECOURS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-07-3106 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan. 16, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
716 N. Carrollton Ave. | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Security Guard | | 16b. Kind of Business/Industry
N.M. Carroll Home | | |
| 17. Father's Name (First, Middle, Last)
James P. Wilson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Bell | | | | |
| 19a. Informant's Name/Relationship (Type, Print, Granddaughter)
Mrs. Patricia Austin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6114 Quiet Times Columbia, Md. 21045 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Date
8/29/2000 | | 20c. Location - City or Town, State
Glen Burnie, Md. 21045 | | |
| 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RECURRENT LUNG CARCINOMA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Thomas S. Wilson | | 29c. License number
D 30272 | | 29d. Date signed (Month, Day, Year)
Aug 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS S. WILSON BON SECOURS HOSPITAL BALTO. MD. | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

00 27152

ORIGINAL

DHHH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27153

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RUTH JESSIE WHITE | | | | 2. Date of Death
Month Day Year
AUGUST 20, 2000 | | 3. Time of Death
9:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
COLONIAL MANOR AT SEVERNA PARK | | | | 4b. City, Town, or Location of Death
SEVERNA PARK | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
192-18-6047 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 28, 1923 | |
| | 9. Birthplace (State or Foreign Country)
WV | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Severn | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
8060 Wayne Rd | | | | 10f. Zip Code
21144 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) CLERK | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERICAL | | 16b. Kind of Business/Industry
CLERICAL | | | |
| | 17. Father's Name (First, Middle, Last)
LAWRENCE RAY LIPSCOMB | | | | 18. Mother's Name (First, Middle, Maiden Surname)
KATE BURGUYNE | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. KATHRYN HITTLE (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8060 WAYNE ROAD, SEVERN, MARYLAND 21144 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEMETERY | | 20c. Date
8/23/2000 | | 20d. Location - City or Town, State
BROOKLYN PARK, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
SINGLETON FUNERAL HOME, P.A.,
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MULTI INFARCT DEMENTIA
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
c. DYSRHYTHMIA
Due to (or as a consequence of):
d. TOBACCO USE | | | | Approximate Interval Between Onset and Death
YEARS
YEARS
YEARS
YEARS | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
CARDIOVASCULAR REFLEX DISEASE | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> M.D. | | 29c. License number
D19991 | | 29d. Date signed (Month, Day, Year)
AUGUST 22, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DANIEL KISS, MD SUITE 412 20015 BRANCH DR GLEN BURNIE MARYLAND 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

ORIGINAL

00-4771-510
UNKNOWN 00-230
JWV
MANCE ALFRED WALLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27154

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mance A. Walls Jr;

2. Date of Death

AUGUST 22, 2000

3. Time of Death

11:07 P.M.

4a. Facility Name (If not institution, give street and number)

3300 BLOCK DOLEFIELD AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

212-76-5240

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

29

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/13/71

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

29 S. Hilton Street.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employer

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

Mance Walls Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carrie B. Walls

19a. Informant's Name/Relationship (Type, Print)

Carrie B. Walls Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 S. Hilton St, Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cem.

Date

8/28/00 Baltimore, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Estep Bros Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

8/22/00

28b. Time of Injury

P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

on Ave on STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3300 Blk Dolefield Ave

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lloyd M. Estep

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 23, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Locke MD 111 Penn Street, Baltimore, Maryland 21201

31. Date (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27155

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---------------------------------|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>William Wade</u> | | 2. Date of Death
Month <u>August</u> Day <u>20</u> Year <u>2000</u> | | 3. Time of Death
<u>18:44</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>The Johns Hopkins Hospital Baltimore City</u> | | 4b. City, Town, or Location of Death
<u>Baltimore City</u> | | 4c. County of Death
<u>N/A</u> |
| Funeral
Director | 5. Social Security Number
<u>281 80 2728</u> | 6. Sex
<u>2</u> M <u>2</u> F | 7. Age (In yrs. last birthday)
<u>38</u> Yrs. | 8. Date of Birth (Month, Day, Year)
<u>May 16, 1962</u> | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Maryland</u> | 10b. County
<u>N/A</u> | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<u>Yes</u> <u>2</u> No |
| | 10e. Street and Number
<u>4201 TOWSON AVE</u> | | 10f. Zip Code
<u>21215</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<u>1</u> Never Married <u>2</u> Married
<u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<u>1</u> Yes <u>2</u> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<u>1</u> Yes <u>2</u> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>9th grade</u> College (1-4 or 5+) <u>College</u> | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Sanitation Worker</u> | | 16b. Kind of Business/Industry
<u>Cuckys Trash Removal</u> | | |
| | 17. Father's Name (First, Middle, Last)
<u>James Wade</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>LOUISE BROWN</u> | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>SHIRLEY RICHARDSON / sister</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3920 REISTERSTOWN ROAD BALTIMORE, MD</u> | | |
| | 20a. Method of Disposition
<u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State
<u>4</u> Donation <u>5</u> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>St. John Cemetery</u> | | 20c. Location - City or Town, State
<u>Baltimore, Maryland</u> |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<u>Gary Pinner</u> | | 22. Name and Address of Facility
<u>CHAPMAN - KARRIS Funeral Home</u>
<u>5340 REISTERSTOWN ROAD BALTIMORE, MD 21215</u> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)
<u>a. Hypotension</u>
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
<u>3 days</u> |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<u>b. upper gastrointestinal bleed</u>
Due to (or as a consequence of): | | | | <u>10 days</u> |
| To Be Completed by Physician/Medical Examiner | <u>c. cirrhosis</u>
Due to (or as a consequence of): | | | | <u>3 months</u> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>thrombocytopenia</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | | | 24a. Was an autopsy performed?
<u>1</u> Yes <u>2</u> No |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<u>1</u> Yes <u>2</u> No | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<u>1</u> Yes <u>2</u> No | | 26. Place of Death (Check only one)
Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | |
| | 27. Manner of Death
<u>1</u> Natural <u>5</u> Pending investigation
<u>2</u> Accident <u>6</u> Could not be determined
<u>3</u> Suicide <u>4</u> Homicide | | 28a. Date of Injury (Month, Day, Year)
<u>Aug 20, 2000</u> | | 28b. Time of Injury
<u>M</u> |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<u>1</u> Yes <u>2</u> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one)
<u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
<u>G. Keith Bruce MD</u> | | 29c. License number
<u>RES-000</u> | | 29d. Date signed (Month, Day, Year)
<u>August 20, 2000</u> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>G. Keith Bruce, MD 600 N. Wolfe Street Baltimore MD 21287</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
<u>AUG 28 2000</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | |
| | State Registrar | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27156

Certificate of Death

Reg. No.

Physician
(Medical
Examiner)Funeral
Director

1. Decedent's Name (First, Middle, Last)

AGNES

A

WILSON

2. Date of Death

Month

Day

Year

August 23, 2000

3. Time of Death

11:35 PM

4a. Facility Name (If not institution, give street and number)

GENIUS ELDER CARE BRIGHTWOOD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

213-32-3076

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-22-36

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

515 BRIGHTFIELD ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)
FOOD PREPARATION

16b. Kind of Business/Industry

FOOD SERVICE

17. Father's Name (First, Middle, Last)

GEORGE PARKER

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE T DUTTON

19a. Informant's Name/Relationship (Type, Print)

RUSSELL MC GOWENS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7100 RUTH GARDEN ROAD BALTIMORE MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

8-29-00

20c. Location - City or Town, State

QUINTON, MD

21. Signature of Funeral Service Licensee

W. J. S. Howell

22. Name and Address of Facility

HOWELL FUNERAL HOME
4600 BRIGHTFIELD AVE
BALTIMORE, MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Amyotrophic Lateral Sclerosis (ALS)

Due to (or as a consequence of):

1 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Boone Cohen MD

29c. License number

041297

29d. Date signed (Month, Day, Year)

8/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boone Cohen MD 714 Security Blvd Baltimore MD 21141

31. Date filed (Month, Day, Year)

AUG 28 2000

32. Registrar's Signature

Boone Cohen

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

after death with the Maryland Department of Health and Mental Hygiene. If, on forms 23a or 23a-f show any injury or other traumatic, etc. permit. Page Important: If item 27 is 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27157

| | | | | | |
|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CORNELL WEBSTER | | 2. Date of Death
Month AUG Day 22 Year 2000 | | 3. Time of Death
1:18 Am |
| | 4a. Facility Name (If not institution, give street and number)
BON SECOURS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
214-56-3329 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
APRIL 22, 1951 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
MARYLAND | | 10b. County
N/A |
| | 10c. City, Town or Location
BALTIMORE CITY | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1621 MOSHER STREET | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9TH GRADE College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HANDY MAN | |
| 16b. Kind of Business/Industry
SELF-EMPLOYED | | 17. Father's Name (First, Middle, Last) (LAST NAME UNKNOWN)
CORNELL | | 18. Mother's Name (First, Middle, Maiden Surname)
FAVE WEBSTER | |
| 19a. Informant's Name/Relationship (Type, Print)
ELOISE SMITH (AUNT) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 WEST 20TH STREET, APT 3-T, BALTO. MD. 21218 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WESTERN STAR CEMETERY | | 20c. Location - City or Town, State
8-29-00 CATONSVILLE, MD. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME
3140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D30272 | |
| 29d. Date signed (Month, Day, Year)
AUG 22 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS S. MILLER BON SECOURS HOSPITAL BALTIMORE, MD | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | |

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #20B PER F.H. G786 8-28-00

Reg. No.

00 27158

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|--|--|---|--|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>William Wyatt</i> | | | | 2. Date of Death
Month <i>8</i> Day <i>18</i> Year <i>00</i> | | 3. Time of Death
<i>3:30 A.M.</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Long Green Center</i> | | | | 4b. City, Town, or Location of Death
<i>Balto</i> | | 4c. County of Death
<i>N/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>219-38-8017</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>58</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>APRIL 28, 1942</i> | 9. Birthplace (State or Foreign Country)
<i>MARYLAND</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MARYLAND</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>BALTIMORE CITY</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>1600 MT ROYAL AVE, APT 414</i> | | 10f. Zip Code
<i>21217</i> | | 10g. Citizen of What Country?
<i>USA.</i> | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>CEMENT FINISHER</i> | | 16b. Kind of Business/Industry
<i>BALTO CITY GOVERNMENT</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>BENJAMIN</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>WYATT ETHEL GROSS</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>HILARY WYATT (DAUGHTER)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4631 REISTERSTOWN ROAD, BALTO, MD. 21215</i> | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>METRO CREMATORY</i> | | Date
<i>8-25-00</i> | | 20c. Location - City or Town, State
<i>BALTIMORE, MARYLAND</i> | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>JOSEPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE., BALTIMORE, MD. 21217</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Colon Cancer with hepatic mets</i>
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d.</i> | | | | | | | | Approximate Interval Between Onset and Death
<i>months</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>D20333</i> | | 29d. Date signed (Month, Day, Year)
<i>8/25/00</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>K. ZONES MD 1838 GREENTREE RD PIRERACCE MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 28 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27159

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANITA L. WEINAPPLE | | 2. Date of Death
Month Day Year
Aug. 22, 2000 | | 3. Time of Death
10:55 AM |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical System | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
214-44-0819 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
57 Yrs. | 8. Date of Birth (Month, Day, Year)
MAY 26, 1943 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
BALTIMORE | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
16 JOANNA COURT | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER |
| To Be Completed by Physician/Medical Examiner | 16b. Kind of Business/Industry
OWN HOME | | 17. Father's Name (First, Middle, Last)
ABRAHAM KAHN | | 18. Mother's Name (First, Middle, Maiden Surname)
MAY FORMAN |
| | 19a. Informant's Name/Relationship (Type, Print)
ABRAHAM WEINAPPLE / HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 JOANNA COURT - BALTIMORE, MD 21208 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OHEB SHALOM MEMORIAL PARK | | 20c. Location - City or Town, State
REISTERSTOWN, MD |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute Renal Failure | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
LESSAR | | 29c. License number
P13129 | |
| 29d. Date signed (Month, Day, Year)
Aug. 24, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeffrey Lessor, Resident Physician, 22 South Greene St. Baltimore, Md 21201 | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
 | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27160

| | | | | | | |
|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elsie G. Yaffe | | 2. Date of Death
Month Day Year
AUG. 24, 2000 | | 3. Time of Death
1931 PM | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
138-16-9118 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 22, 1923 |
| | 9. Birthplace (State or Foreign Country)
Newark, N. J. | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number
1001 Aliceanna St., Apt. 504 | | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sect'y/Bookkeeper | | 16b. Kind of Business/Industry
Banking | | |
| 17. Father's Name (First, Middle, Last)
Isadore Gorfman | | | 18. Mother's Name (First, Middle, Maiden Surname)
Fannie | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Benjamin Yaffe-Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1101 Aliceanna St., Apt. 504, Baltimore, MD 21202 | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | Date
8/28/00 | 20c. Location - City or Town, State
Towson, MD | |
| 21. Signature of Funeral Service Licensee
William G. Dau | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Rd., Baltimore, MD 21214 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| | a. ASPHYXIATION
Due to (or as a consequence of):
b. CHOKING ON A FOOD BOLUS
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SJOGRENS SYNDROME
ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/24/00 | | 28b. Time of Injury
1030 PM | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
AT HOME | | 28d. Describe how injury occurred SUBJECT CHOKED ON A BOLUS OF FOOD
28f. Location (Street and Number or Rural Route Number, City or Town, State)
1001 ALICEANNA ST BALTIMORE MD | | | | |
| 29e. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUG. 26, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPLEY MD, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27161

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Laverne Alda Ziemba | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | | | 3. Time of Death
1:40 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Timonium | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
219-14-1656 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan 15, 1919 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Middle River | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
646 Kittendale Circle | | | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) House wife | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House wife | | | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Clarence Anders | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Seece | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Nancy Carol Goldberg (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
646 Kittendale Circle, Baltimore, Maryland 21220 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Balto. Nat'l. Cemetery | | Date
8/29/2000 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bruzdinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Lung Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
DH3725 | | | | 29d. Date signed (Month, Day, Year)
8/28/00 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221 | | | | | | | | | |
| 4/5 | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | | |

ORIGINAL

Antwon Alonzo Anderson

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|---------------------------------------|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Antwon Alonzo Anderson | | | | 2. Date of Death
Month Day Year
AUGUST 27, 2000 | | | | 3. Time of Death
12:55 A.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
2300 DENISON STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | | | |
| Funeral
Director | 5. Social Security Number
577-98-8168 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
19 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-29-80 | | 9. Birthplace (State or Foreign Country)
DC | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
7216 McClean Blvd. | | | | 10f. Zip Code
21234 | | | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify:
Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade
College (1-4or 5+)
NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Improvement | | | | 16b. Kind of Business/Industry
self-employed | | | | | |
| 17. Father's Name (First, Middle, Last)
Harry Ellsworth Anderson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Deborah Davis | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ann Davis | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7216 McClean Blvd. Baltimore, Maryland 21234 | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Voshell Mem. Gardens 08-31-2000 Dundalk, MD | | | | 20c. Location - City or Town, State | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

MULTIPLE GUNSHOT WOUNDS
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/27/00 | | 28b. Time of Injury
10:55AM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT WAS SHOT | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
STREET | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2300 DENISON ST BALTIMORE MD | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 27, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Mary G. Ripple 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
 | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27163

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIE ALFORD JR. | | | 2. Date of Death
Month Aug Day 23 Year 2000 | | 3. Time of Death
2145 | | |
| | 4a. Facility Name (If not institution, give street and number)
MERCY HOSPITAL | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
247-27-9188 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
37 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 13, 1963 | |
| | 9. Birthplace (State or Foreign Country)
South Carolina | | 10a. State
md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
533 Sheridan Ave | | 10f. Zip Code
21212 | | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BRICK MAKER | | 16b. Kind of Business/Industry
BRICK Industry | | |
| 17. Father's Name (First, Middle, Last)
JOHN Alford JR. | | 18. Mother's Name (First, Middle, Maiden Surname)
Norrie Covington | | 19a. Informant's Name/Relationship (Type, Print)
Betty Covington - Aunt | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
533 Sheridan Ave. Balto. md. 21212 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MTIZION CEMETERY | | Date
8/30/00 | | 20c. Location - City or Town, State
Lansdowne, md. | | |
| 21. Signature of Funeral Service Licensee
Lewis T. Gwynn | | 22. Name and Address of Facility
LEWIS T. Gwynn Funeral Home | | 4517 Park Heights Ave. Balto. md. 21215-6393 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Pancreatitis
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
24 h. | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | 28b. Time of Injury
1 Yes 2 <input type="checkbox"/> No | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
Joseph Costa, MD | | | | | | |
| 29c. License number
D42634 | | 29d. Date signed (Month, Day, Year)
AUG 23, 2000 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH COSTA 301 ST PAUL PLACE BALTIMORE, MD 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
Benjamin B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27164

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Norwood Bennett

2. Date of Death

August 26 2000

3. Time of Death

11:12 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-12-0555

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 25, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7946 Kavanagh Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
9 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Linefeeder

16b. Kind of Business/Industry

Automobile Industry
General Motors

17. Father's Name (First, Middle, Last)

Lawrence E. Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Holtmann

19a. Informant's Name/Relationship (Type, Print)

John Bennett (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7946 Kavanagh Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gdns. 8/30/2000

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

C. Canell

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Right pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

12 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure Secondary to Pacemaker

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. L. L. MD

29c. License number

RD 192476

29d. Date signed (Month, Day, Year)

8/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geo-Phillips Chacko, MD. 9000 Franklin Square Drive. Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

[Signature]

State Registrar

ORIGINAL

Bennett, Lawrence
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27165

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNETTE MARION NOVAK BERRY | | | | 2. Date of Death
Month Day Year
AUGUST 23 2000 | | 3. Time of Death
08:26 | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-72-5430 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 25, 1957 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Cecil Co. | | 10c. City, Town or Location
Elkton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
300 Jackson Hall School Road | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Medical Technician | | 16b. Kind of Business/Industry
Health Care | | | |
| | 17. Father's Name (First, Middle, Last)
Andrew F. Novak | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna M. Kues | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mr. Steven D. Berry (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
300 Jackson Hall School Rd. Elkton, MD 21921 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Polish Na. Cem | | 20c. Location - City or Town, State
Dundalk, Maryland | | 20d. Date
8/28/2000 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Disseminated intravascular coagulation
Due to (or as a consequence of):

b. Metastatic adenocarcinoma, favor a pulmonary or a breast primary
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D28885 | | 29d. Date signed (Month, Day, Year)
8/24/00 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard L. Siegel, M.D. 6701 N. Charles Street, Baltimore MD 21204 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
 | | | |

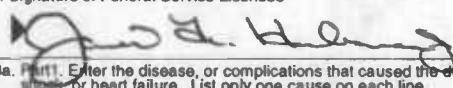
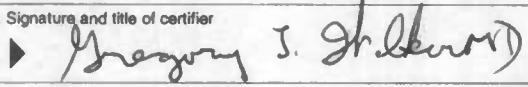
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27166

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|---------------------------------------|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lewis Joseph Baumann | | | | 2. Date of Death
Month Day Year
August 23, 2000 | | | | 3. Time of Death
7:30 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
8 Knoll Ridge Court; Apt. 1721 | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
217-03-1801 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 18, 1912 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
8 Knoll Ridge Court; Apt 1721 | | | | 10f. Zip Code
21210 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Building Specialty Sales | | | | 16b. Kind of Business/Industry
Lewis J. Baumann, Inc. | | | |
| 17. Father's Name (First, Middle, Last)
Jacob A. Baumann | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Harriet Estelle Johnson | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Evelyn E. Baumann (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Knoll Ridge Court Apt. 1721; Baltimore, MD 21210 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Date
8/26/00 | | 20d. Location - City or Town, State
Woodlawn, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Road, Randallstown, MD 21133 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Acute Myocardial Infarction</u>
Due to (or as a consequence of):
b. <u>Coronary Artery Disease</u>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
Secs | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
P25662 | | 29d. Date signed (Month, Day, Year)
8/23/00 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregory Walker MD 3333 Calvert #5th BALTIMORE MD 21218 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BOYD BERNARD BUTTS | | | | 2. Date of Death
Month Day Year
AUGUST 22 2000 | | 3. Time of Death
0830 | |
| | 4a. Facility Name (If not institution, give street and number)
3060 BEL PRE RD. APT 101 | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
235-64-8378 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
58 Yrs. | | 8. Date of Birth (Month, Day, Year)
6/5/1942 | |
| | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | 10a. State
MD | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3060 BEL PRE RD., APT. 101 | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SENIOR TECHNICAL REPRESENTATIVE | | 16b. Kind of Business/Industry
XEROX | | | | |
| 17. Father's Name (First, Middle, Last)
B. GRANVILLE BUTTS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
RUTH STILWELL | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LAWRENCE E. BUTTS / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111-8 TIMBERLAKE TERRACE, STEPHENS CITY, VA 22655 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHANGHAI CEMETERY | | Data
8/25/00 | | 20c. Location - City or Town, State
R.F.D. HEDGESVILLE, WV | | |
| 21. Signature of Funeral Service Licensee
Charles M. Brown | | | | 22. Name and Address of Facility
BROWN FUNERAL HOME, 327 W. KING ST.,
PO BOX 821, MARTINSBURG, WV 25402 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Arteriosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUGUST 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Talon Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
[Signature] | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27168

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY

BROTMAN-MINTZ

2. Date of Death

Month Day Year
AUGUST 25, 2000

3. Time of Death

9:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOSPICE OF BALTIMORE - GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

217-12-0396

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 1, 1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

124 HARRY LANE #C

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER OPERATOR

16b. Kind of Business/Industry

STATE OF MARYLAND

17. Father's Name (First, Middle, Last)

BENJAMIN

18. Mother's Name (First, Middle, Maiden Summa)

GLASSMAN

EDITH

REAMER

19a. Informant's Name/Relationship (Type, Print)

RANDI BROTMAN-ROSEN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

120 HARRY LANE #A - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

8/28/00

20c. Location - City or Town, State

PIKESVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Approximate Interval Between Onset and Death

15 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

225205

29d. Date signed (Month, Day, Year)

August 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley, GMC 6701 N. Charles St. Balto. MD 21208

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

State Registrar

August 25, 2000 9:15 P.M.
Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.
SHIRLEY BROTMAN-MINTZ
Division of Vital Records, P.O. Box 68760,
yF 10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27169

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CECILIA CURRY

2. Date of Death

Month

Day

Year

August 25 2000

3. Time of Death

6:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

148-16-1877

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 22 1925

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10214 Bevens Lane

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joshua Kaminiski

18. Mother's Name (First, Middle, Maiden Surname)

Cecilia Simmons

19a. Informant's Name/Relationship (Type, Print)

Fern Knight / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10214 Bevens Lane Baltimore MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Cemetery

Date

8/29/2000

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Maurice Hann MD

29c. License number

D40819

29d. Date signed (Month, Day, Year)

August 26, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr Zamora / 9000 Franklin Square Drive Baltimore, MD. 21237

31. Date filed (Month, Day, Year)

AUG 25 2000

32. Registrar's Signature

B. B. B.

State
Registrar

ORIGINAL

Curry, Cecilia
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27170

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret Freida Cole | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | 3. Time of Death
7:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
1718 Leslie Road | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-03-4070 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 16, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Dundalk | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10a. Street and Number
1718 Leslie Road | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Years
College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cafeteria Worker | | 16b. Kind of Business/Industry
Baltimore Co. Schools | | | |
| | 17. Father's Name (First, Middle, Last)
Adam K. Dumbrowsky | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Kaiphas | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Dorothy J. Weller Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1206 Saltspray Lane Pasadena, Maryland 21122 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Ht. of Jesus Cem. | | Date
8/30/2000 | | 20c. Location - City or Town, State
Dundalk, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>arrhythmia</u>
Due to (or as a consequence of):
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
D42232 | | 29d. Date signed (Month, Day, Year)
8/28/00 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2112 Dundalk Ave, Baltimore, MD 21222, Scott Feeser, MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27171

| | | | | | | | | |
|---|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Orlando W. Chapman | | | | 2. Date of Death
Month Day Year
August 28, 2000 | | 3. Time of Death
7:40 A | |
| | 4a. Facility Name (If not institution, give street and number)
Levindale | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-78-1673 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
8 1 1962 | |
| | 9. Birthplace (State or Foreign Country)
Md | | 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| Usual Residence of Decedent | | | | | | | | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
5342 Cuthbert Avenue | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U S A | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (14 or 5+) 2 years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electrical Engineer | | 16b. Kind of Business/Industry
Md Cup Company | | |
| 17. Father's Name (First, Middle, Last)
Louis Chapman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Joan Branch | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan Chapman - Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5342 Cuthbert Avenue Baltimore, Md 21215 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery | | 20c. Location - City or Town, State
9-1-00 Baltimore, Md | | | |
| 21. Signature of Funeral Service Licensee
<i>March</i> | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Amyloidosis
Due to (or as a consequence of):
b. Pressure Sores
Due to (or as a consequence of):
c. Chronic Renal Failure
Due to (or as a consequence of):
d. T11 Paraplegia secondary to gunshot
Approximate Interval Between Onset and Death
yrs
yrs
yrs
yrs | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Debra Wertheimer MD</i> | | | | 29c. License number
D 23767 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Debra Wertheimer MD 2434 W. Belvedere Ave, Balto, Md 21215 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
<i>Debra Wertheimer</i> | | | | | |
| State Registrar | | | | | | | | |

ORIGINAL

W. E. B. DuBois

My dear

I have been thinking of you
and the work you are doing
and the people you are helping

X X X

Very truly yours
W. E. B. DuBois

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27172

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Calvin D Cook</u> | | | 2. Date of Death
Month <u>August</u> Day <u>20</u> Year <u>2000</u> | | 3. Time of Death
<u>1048</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>St. Agnes Health Care</u> | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>BALTIMORE</u> | |
| Funeral
Director | 5. Social Security Number
<u>244-28-8746A</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>74</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>MARCH 13, 1926</u> | |
| | 10a. State
<u>MARYLAND</u> | | 10b. County
<u>BALTIMORE CITY</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u></u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>SUPERVISOR</u> | | 16b. Kind of Business/Industry
<u>REAL ESTATE</u> | |
| 17. Father's Name (First, Middle, Last)
<u>LESTER COOK</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>LILLIE MAY ECHOLS</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>IRENE COOK - WIFE</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2204 WILKENS AVENUE, BALTIMORE, MARYLAND 21223</u> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u></u> | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>LOUDON PARK CEMETERY</u> | | 20c. Location - City or Town, State
<u>8-25-00 BALTIMORE, MARYLAND</u> | |
| 21. Signature of Funeral Service Licensee
<u>Lisa S. Jefferson</u> | | | | 22. Name and Address of Facility
<u>LOUDON PARK FUNERAL HOME
3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Hemorrhagic shock</u>
Due to (or as a consequence of): <u></u>

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<u>b. massive Gg bleed</u>
Due to (or as a consequence of): <u></u>

<u>c.</u>
Due to (or as a consequence of): <u></u>

<u>d.</u>
Due to (or as a consequence of): <u></u> | | | | Approximate Interval Between Onset and Death
<u>12-24 hrs</u>
<u>12-24 hrs</u> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Lung CA mets, DM, ASCVD,</u>
<u>ORT/PG - A.Fib</u> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u></u> | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
<u></u> | | 28b. Time of Injury
<u>M</u> | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred
<u></u> | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
<u></u> | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
<u></u> | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | | | 29b. Signature and title of certifier
<u>M. Aradi, PGY II</u> | | | |
| 29c. License number
<u>P13598</u> | | | | 29d. Date signed (Month, Day, Year)
<u>8/20/00</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Mehdi Aradi, St. Agnes Hosp. Baltimore, MD</u> | | | | 31. Date filed (Month, Day, Year)
<u>AUG 29 2000</u> | | | |
| 32. Registrar's Signature
<u>B. Sparks</u> | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 27173

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert Thomas Curran | | | | 2. Date of Death
Month Day Year
August 25 2000 | | | 3. Time of Death
07:50 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
2514 South Snyder Avenue | | | | 4b. City, Town, or Location of Death
Edgemere | | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
214-64-3796 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG 22, 1956 | | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Edgemere | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2514 South Snyder Avenue | | | | 10f. Zip Code
21219 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Security | | | 16b. Kind of Business/Industry
Transportation | | |
| | 17. Father's Name (First, Middle, Last)
James F. Curran | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Blanche Gurzon | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Blanche Curran/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
327 Stonewall Rd. Catonsville, MD 21228 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | 20c. Location - City or Town, State
Baltimore, MD | | 20d. Date
8-28-00 | |
| | 21. Signature of Funeral Service Licensee
Thomas Gregor | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 23c. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Dennis J. Chute
29c. License number
O.C.M.E.
29d. Date signed (Month, Day, Year)
August 26, 2000 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000
32. Registrar's Signature
B. Sparks | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27174

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Walter J. Compton | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
1:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
16015 Frederick Rd. | | | | 4b. City, Town, or Location of Death
Lisbon | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
231-36-8174 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 31, 1933 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Lisbon | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
16015 Frederick Rd. | | 10f. Zip Code
21765 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1953 1955 | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) College | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Pastor | | | | 16b. Kind of Business/Industry
Religion | | 17. Father's Name (First, Middle, Last)
Noah Compton | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Cleo Thomas | | | | 19a. Informant's Name/Relationship (Type, Print)
Ms. Janice M. Compton Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16015 Frederick Rd. Lisbon, Maryland 21765 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crest Lawn Memorial Gardens | | 20c. Date
08/26/2000 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Malignant Mesothelioma
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year)
8/25/00 | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D 22101 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
8/25/00 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lloyd Halvorson 1475 Lang Ave. Frederick Md 21704 | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | |
| | 32. Registrar's Signature
<i>[Signature]</i> | | | | 33. State Registrar
State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |

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State of Maryland / Department of Health and Mental Hygiene 00 27175

AMENDED ITEM #10e PER FH G786 8/29/00 AH

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--------------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALBERT L. CLEMENTE | | | | 2. Date of Death
Month Day Year
AUGUST 25 2000 | | 3. Time of Death
9:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
5423 Windward Drive | | | | 4b. City, Town, or Location of Death
Tilghman | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
050-16-2461 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 25, 1921 | | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Talbot | | 10c. City, Town or Location
Tilghman | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
5423 Windward Drive | | | | 10f. Zip Code
21671 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs.
College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Quality Control | | 16b. Kind of Business/Industry
Edgewood Arsenal | | |
| 17. Father's Name (First, Middle, Last)
Carmine Clemente | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rachel Irene Vitali | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Gladys M. Clemente (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5423 Windward Drive Tilghman, Maryland 21671 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
8-28-2000 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Donald C. Chasala</i> | | | | 22. Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Maryland 21236 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Chronic obstructive pulmonary disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | |
| Approximate Interval Between Onset and Death
Years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus, Coronary Artery Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Ludwig J. Eglseider</i> | | | | 29c. License number
D 31466 | | 29d. Date signed (Month, Day, Year)
8/25/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LUDWIG J. EGLSEDER III, M.D. 606 DUTCHMANS LN, EASTON, MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
<i>Sparks</i> | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27176

| | | | | | | | | | | | | | | |
|--|---|------------------------|---|---|--|--|--------------------------------|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marlene R. Danielson | | | | 2. Date of Death
Month Day Year
AUGUST 21 2000 | | | | 3. Time of Death
20:50 PM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
2135 HARKINS ROAD | | | | 4b. City, Town, or Location of Death
PYLESVILLE | | | | 4c. County of Death
HARFORD | | | | | |
| Funeral
Director | 5. Social Security Number
220-42-8064 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
56 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth
(Month, Day, Year)
Jan 5, 1944 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Harford | | 10c. City, Town or Location
Pylesville | | | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number
2135 Harkins Road | | | | 10f. Zip Code
21132 | | | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify:
White | | | | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Home | | | | | | |
| 17. Father's Name (First, Middle, Last)
Robert Carter | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Brockmeyer | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Brian Danielson-Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3909 Walter Road, Edgewood MD 21040 | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Darlington Cemetery | | Date
Aug 25 2000 | | 20c. Location - City or Town, State
Darlington, MD | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Evans Funeral Chapel
3 Newport Drive Forest Hill, MD | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Chronic Alcoholism with
Due to (or as a consequence of):
b. Dilated Cardiomyopathy and
Due to (or as a consequence of):
c. Fatty metamorphosis of the
Due to (or as a consequence of):
d. Liver

Approximate Interval Between Onset and Death | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to this cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury
(Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier
(Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 22, 2000 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27177

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KERN JAMES DUCOTE, SR. | | | | 2. Date of Death
Month Day Year
AUGUST 21 2000 | | 3. Time of Death
9:17PM | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
433-46-8358 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 28, 1934 | |
| | 9. Birthplace (State or Foreign Country)
LOUISIANA | | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
BALTIMORE | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
PARKVILLE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3117 SUMMIT AVE | | 10f. Zip Code
21234 | |
| | 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: ARMY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SUPERINTENDANT | | 16b. Kind of Business/Industry
LAWRENCE CONSTRUCTION CO. | |
| | 17. Father's Name (First, Middle, Last)
AUEN DUCOTE, SR. | | 18. Mother's Name (First, Middle, Maiden Surname)
IVY BRASSETTE | | 19a. Informant's Name/Relationship (Type, Print)
LORETTA DUCOTE, SPOUSE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3117 SUMMIT AVE. PARKVILLE, MD. 21234 | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL MEM. GDNS. | | 20c. Location - City or Town, State
MIDDLE RIVER, MD. | | 20d. Date
AUG 25 2000 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
8800 HARFORD RD. PARKVILLE, MD 21234 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Non-Hodgkin's Lymphoma | | Approximate Interval Between Onset and Death
1 year | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rectal Cancer
Hairy cell leukemia | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> MD | | 29c. License number
D 38929 | | 29d. Date signed (Month, Day, Year)
8/22/2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Celars, MD 6569 N. Charles ST, BALT. MD 21209 | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | |
| | State Registrar | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27178

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES DELUNGER | | | | 2. Date of Death
Month August Day 27 Year 2000 | | 3. Time of Death
9:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Harbor Hospital Center | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-20-8420 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1928 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
198 German Hill Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Rail Road Yard Master | | 16b. Kind of Business/Industry
Patapsco Rail Road | | 17. Father's Name (First, Middle, Last)
James L. Dellinger, Sr. | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Edna Clark | | 19a. Informant's Name/Relationship (Type, Print) (Wife)
Mrs. Shirley J. Dellinger | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
198 German Hill Road Dundalk, Maryland 21222 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. | | 20c. Date
8/30/2000 | | 20d. Location - City or Town, State
Rossville, Maryland | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. non small cell ca of left lung & metastasis to brain. | | Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | Approximate Interval Between Onset and Death
17 month | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | |
| 28b. Time of Injury
1 Yes <input type="checkbox"/> No | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Ismael Bobat M.D. | | 29c. License number
P12792 | | |
| 29d. Date signed (Month, Day, Year)
August 27, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ISMAEL BOBAT 3001 S. HANOVER ST. BALTIMORE, MD 21225 | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27179

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---------------------------------|---|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward William Drumgoole | | | | | | 2. Date of Death
Month Day Year
August 26, 2000 | | 3. Time of Death
9:05 PM | |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE Hospital Center | | | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
219-38-1997 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
57 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 26 1942 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Oliver Beach | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
13205 Eastgreenbank Rd. | | | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Executive V.P., N.I.L.P. | | | 16b. Kind of Business/Industry
Insurance | | | |
| 17. Father's Name (First, Middle, Last)
Elmer E. Drumgoole | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Mary Gray | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Elizabeth H. Drumgoole/wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13205 Eastgreenbank Rd., Oliver Beach, MD 21220 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | | 20c. Location - City or Town, State
Beltsville, MD | | 20d. Date
8/29/00 | | |
| 21. Signature of Funeral Service Licensee
Michael J. Flagle | | | 22. Name and Address of Facility
Lemmon Funeral Home
10 W. Padonia Rd., Timonium, MD 21093 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
INTRA CEREBRAL HEMORRHAGE
Due to (or as a consequence of):
HYPERTENSION
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Dennis Odie MD | | | 29c. License number
192690 | | | 29d. Date signed (Month, Day, Year)
August 26, 2000 | | | | |
| 30. Name and address of person who completed cause of death (List 23a) (Type, Print)
DENNIS ODIE, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, Maryland | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
[Signature] | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene 00 27180

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>MARY Frances Dobson</i> | | | | 2. Date of Death
Month Day Year
<i>AUGUST 24, 2000</i> | | 3. Time of Death
<i>5:33 A.M.</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>SAINT AGNES Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | | |
| Funeral
Director | 5. Social Security Number
<i>220-03-9084</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>92</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>May 24 1908</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>md.</i> | 10b. County
<i>N/A</i> | 10c. City, Town or Location
<i>Baltimore</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
<i>833 W. Pratt Street Apt. 206</i> | | | | 10f. Zip Code
<i>21201</i> | | 10g. Citizen of What Country?
<i>U.S.A</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>CLERK</i> | | 16b. Kind of Business/Industry
<i>U.S. Post office</i> | | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Isaac Dobson</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Frances Scott</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Ricky Frazier-Grand Nephew</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5225 Wagonshed circle</i> | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Arbutus memorial PK.</i> | | Data
<i>8/28/00</i> | | 20c. Location - City or Town, State
<i>Balto. md.</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>Lewis T. Guyan</i> | | 22. Name and Address of Facility
<i>Lewis T. Guyan Funeral Home
4517 Park Heights ave. Balto. md. 21215-6393</i> | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Atherosclerotic Coronary Vascular Disease</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Scott Bergeson MD</i> | | | | 29c. License number
<i>D0055849</i> | | 29d. Date signed (Month, Day, Year)
<i>August 24, 2000</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>SCOTT BERGESON</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | 32. Registrar's Signature
<i>Sparks</i> | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27181

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--------------------------------|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Edith Louise Elliott</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>25</i> Year <i>2000</i> | | 3. Time of Death
<i>6:30 am</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Stella Maris</i> | | | | 4b. City, Town, or Location of Death
<i>Timonium</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>216-22-4902</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>89</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
<i>Sept 3, 1910</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Md</i> | 10b. County
<i>Baltimore</i> | 10c. City, Town or Location
<i>Timonium</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>2300 Dulaney Valley Rd.</i> | | | 10f. Zip Code
<i>21093</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i> | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>homemaker</i> | | 16b. Kind of Business/Industry
<i>home</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>William Sanner</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Fannie Biddison</i> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Georgia Erbbeck daug.</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>8412 Old Harford Rd. Baltimore Md 21234</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Mossland Mem. Park</i> | | 20c. Location - City or Town, State
<i>Parkville, Md</i> | | 20d. Date
<i>Aug. 28</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Heidi S. Wells</i> | | | | 22. Name and Address of Facility
<i>Evans Funeral Chapel</i>
<i>2325 York Rd. Timonium, Md 21093</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | Immediate Cause (Final disease or condition resulting in death) | | a. <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>
Due to (or as a consequence of): | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | | | |
| | | | c. Due to (or as a consequence of): | | | | | |
| | | | d. Due to (or as a consequence of): | | | | | |
| | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Tariq Mahmood</i> | | | | 29c. License number
<i>D43725</i> | | 29d. Date signed (Month, Day, Year)
<i>8/25/00</i> | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27182

| | | | | | | | | |
|---|--|--------------------|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gertrude Eleanor Martha ELLIS | | | | 2. Date of Death
Month Day Year
AUG. 23, 2000 | | 3. Time of Death
10:38 AM | |
| | 4a. Facility Name (If not institution, give street and number)
4025 Fairfax Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-30-9045 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov. 11, 1935 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
md | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4025 Fairfax Rd. | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No. Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DAY CARE PROVIDER | | 16b. Kind of Business/Industry
SELF EMPLOYED | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
John Otha Allen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruth molder | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James Ellis - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4728 Three Oaks Rd. Pikesville, md. 21208 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Nat'l cem | | Date
8/29/00 | 20c. Location - City or Town, State
Catonville, md. | | |
| | 21. Signature of Funeral Service Licensee
Lewis T. Guyon | | 22. Name and Address of Facility
Lewis T. Guyon Funeral Home
4512 Park Heights Ave. Balto. md. 21215 | | | | | |
| Physician
/Medical
Examiner | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of): | | | | | | | |
| | b. Chronic Coronary Artery Disease
Due to (or as a consequence of): | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
d. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
N/A M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | 28d. Describe how injury occurred | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Richard M. Hunt MD | | | | 29c. License number
D-13619 | | 29d. Date signed (Month, Day, Year)
8-28-00 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard M. Hunt MD 2300 Anderson Blvd. 21216 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
B. Sparks | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27183

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Helen Elderkin</u> | | | | 2. Date of Death
Month <u>August</u> Day <u>25</u> Year <u>2000</u> | | | | 3. Time of Death
<u>6:30 AM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>2008 Greenspring Valley Rd.</u> | | | | 4b. City, Town, or Location of Death
<u>Stevenson</u> | | | | 4c. County of Death
<u>Baltimore</u> | |
| Funeral
Director | 5. Social Security Number
<u>235-22-5378</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>77</u> Yrs. | | If Under 1 Year
Months Days | | 8. Date of Birth (Month, Day, Year)
<u>Oct. 16, 1922</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>W. Va.</u> | | 10a. State
<u>Md.</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Stevenson</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10e. Street and Number
<u>2008 Greenspring Valley Rd.</u> | | | | 10f. Zip Code
<u>21153</u> | | | | 10g. Citizen of What Country?
<u>USA</u> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Home maker</u> | | | | 16b. Kind of Business/Industry
<u>Own home</u> | | |
| 17. Father's Name (First, Middle, Last)
<u>George D. chittum</u> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>May Hall</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Mr. C. Eugene Elderkin, III/son</u> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>4002 Millender Rd. Reisterstown, Md. 21136</u> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Druid Ridge Cemetery</u> | | | Date
<u>8/28/00</u> | | 20c. Location - City or Town, State
<u>Pikesville, Md.</u> | |
| 21. Signature of Funeral Service licensee
 | | | | 22. Name and Address of Facility
<u>Ruck Towson Funeral Home, Inc.</u>
<u>1050 York Rd. Towson, Md. 21204</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>Lung Cancer - Metastatic</u>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>Chimene L Liburd MD</u> | | | | | | 29c. License number
<u>D0054020</u> | | 29d. Date signed (Month, Day, Year)
<u>August 25 2000</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Chimene L Liburd MD 90 Tanlers Mill Rd Sice Owning Mills</u> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 28 2000</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27184

Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|--|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Milton Ferguson | | 2. Date of Death
Month Day Year
August 4, 2000 | | 3. Time of Death
5:45 |
| | 4a. Facility Name (If not Institution, give street and number)
8200 Daren Court | | 4b. City, Town, or Location of Death
Pikesville | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
218-36-2349 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
60 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
10/25/1939 | | 9. Birthplace (State or Foreign Country)
MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
MD | 10b. County
Baltimore | 10c. City, Town or Location
Pikesville | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
8200 Daren Court | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Moulder | | 16b. Kind of Business/Industry
danco Arlington | | |
| | 17. Father's Name (First, Middle, Last)
Cleveland Ferguson | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith Davis Ferguson | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Ruby Ferguson-wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8200 Daren Court, Pikesville, MD 21208 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star | | 20c. Location - City or Town, State
8/10/00 Baltimore, MD |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ per DVR | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave., Baltimore, MD 21216 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Renal Failure (acute)
Due to (or as a consequence of):
Probable vasculitis | | | | Approximate Interval Between Onset and Death |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes (glucose intolerance)
Dysproteinemia | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 29d. Date signed (Month, Day, Year)
8/29/00 |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Deborah Morris MD | | |
| | 29c. License number
031364 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
21 Crossroads Dr. #250 Owings Mills MD 21117 | | |
| | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
B Sports | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27185

| | | | | | | | | |
|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kenneth William Franz | | | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
5:25 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris
Mercy Medical Center Hospice Center | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
229-66-7103 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
55 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Dec. 14, 1944 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore City | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10a. Street and Number
23 South Kresson Street | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
11 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Machine Operator | | 16b. Kind of Business/Industry
Scully Rubber Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Harold Holdstead | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sophia Virginia Franz | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Sandra Franz (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 South Kresson St. Baltimore, MD 21224 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | Date
8/28/2000 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colon Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
1 month |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | 29c. License number
D40854 | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27186

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

LOUIS FREDERICK FRIES, Jr.

2. Date of Death

Month Day Year
August 24, 2000

3. Time of Death

2:10 A.M.

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-16-8872

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 22, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

107-F Versailles Circle

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Agricultural/Chemical

17. Father's Name (First, Middle, Last)

Louis Frederick Fries, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marie Magdalena Buehler

19a. Informant's Name/Relationship (Type, Print)

Dr. Louis F. Fries, III (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5432 Tilted Stone Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

8-29-00

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

George J. Fennell

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Approximate Interval Between Onset and Death

10 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley GBMC 6701 N. Charles St. Balt. Md 21204

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

B. Sparks

State
Registrar

FRIES, LOUIS AUGUST 24 '00 @ 2:10 AM

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27187

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|---|---|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JEANETTE FULLER | | | | 2. Date of Death
Month 8 Day 27 Year 2000 | | | | 3. Time of Death
7:00 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
2500 W. BELVEDERE AVE. APT. 614 | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
063-34-2888 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 7 1941 | | 9. Birthplace (State or Foreign Country)
N.Y. | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
2500 W. BELVEDERE AVE. APT. 614 | | | | 10f. Zip Code
21215 | |
| | 10g. Citizen of What Country?
U S A | | | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) NA | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DISABLED | | | | 16b. Kind of Business/Industry
NA | | | | 17. Father's Name (First, Middle, Last)
JAMES FULLER | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
FANNY MILLER | | | | 19a. Informant's Name/Relationship (Type, Print)
VINCENT FULLER - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6408 LEHNERT ST BALTO., MD 21207 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROSEHILL CEMETERY | | | | 20c. Location - City or Town, State
9-1-00 LINDEN, NEW JERSEY | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE. BALTO., MD 21215 | | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
036353 | | |
| 29d. Date signed (Month, Day, Year)
08/28/2000 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Don Bousol 2411 W. Belvedere Ave Baltimore, MD 21215 | | | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | 33. State Registrar
MD | | | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27188

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Theresa Grabill

2. Date of Death

Month Day Year
August 28, 2000

3. Time of Death

1:30am

4a. Facility Name (If not institution, give street and number)

Keswick Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

215 -44-2430

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 21, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

710 West 40th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Samuel Hyman

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve Sweglar

19a. Informant's Name/Relationship (Type, Print)

Laura Grabill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1325 West 41st Street, Baltimore, Maryland 21211

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Evans Funeral Chapel-Bel Air

Date

Aug. 29
2000

20c. Location - City or Town, State

Forest Hill, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Parkville, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Dehydration

Due to (or as a consequence of):

c. Esophageal Reflux / stricture

Due to (or as a consequence of):

d. _____

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

30 min.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sjogrens syndromePolymyalgia RheumaticaHypothyroidismPeripheral Neuropathy

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42129

29d. Date signed (Month, Day, Year)

08-28-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McConnell, 500 W. University Baltimore 21210

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27189

| | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRMA A GUDGEON | | | | 2. Date of Death
Month AUGUST Day 27 Year 2000 | | 3. Time of Death
8:00 am | | |
| | 4a. Facility Name (If not institution, give street and number)
307 North Marlyn Ave. | | | | 4b. City, Town, or Location of Death
Essex | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
219-01-6932 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 9 1915 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
307 North Marlyn Ave. | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Factory Worker | | 16b. Kind of Business/Industry
American Can | | 17. Father's Name (First, Middle, Last)
Leo R Sheldon | | 18. Mother's Name (First, Middle, Maiden Surname)
Estella Nadonley | |
| 19a. Informant's Name/Relationship (Type, Print)
Gloria Haberkam / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1518 Lesley Road Baltimore MD 21222 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery | | 20c. Date
8/31/2000 | | 20d. Location - City or Town, State
Baltimore MD | | | |
| 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 MACE AVE. Baltimore MD 21221 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Metastatic Carcinoma
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): | | | | | | | | | |
| 23c. Due to (or as a consequence of): | | | | | | | | | |
| 23d. Due to (or as a consequence of): | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
S. Milner MD | | 29c. License number
018584 | | 29d. Date signed (Month, Day, Year)
8/24/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sheldon Milner MD 404 Eastern Blvd 21221 | | 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27190

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marie L. Gueuk | | | | 2. Date of Death
Month Aug Day 23rd Year 2000 | | | | 3. Time of Death
4:30am | |
| | 4a. Facility Name (If not institution, give street and number)
Copper Ridge | | | | 4b. City, Town, or Location of Death
Sykesville | | | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
213-46-3753 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 | | 8. Date of Birth (Month, Day, Year)
April 17, 1907 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
5709 Chinquepin Pkwy | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | | 16b. Kind of Business/Industry
Education | | |
| 17. Father's Name (First, Middle, Last)
Chester Kiselewski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Janisewski | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Irene Pula Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5712 Fenwick Avenue Baltimore, Maryland 21239 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
8/28/00 | | 20c. Location - City or Town, State
Hawthorne New York | | | | |
| 21. Signature of Funeral Service Licensee
Dennis Stephen Kenack | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home Inc
6500 York Road Baltimore, Maryland 21212 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Liver Metastases
Due to (or as a consequence of):
b. Unknown Primary Cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
Months | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Ernestine Wnght, MD | | | | 29c. License number
D52740 | | 29d. Date signed (Month, Day, Year)
August 23rd, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ernestine Wnght, Copper Ridge, 710 Obrecht Road, Sykesville MD 21784 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27191

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDITH GRIFFIN | | 2. Date of Death
Month Day Year
AUGUST 26 2000 | | 3. Time of Death
3:30 PM |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
218-07-1840 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
05-28-19 | | 9. Birthplace (State or Foreign Country)
SC | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
NA |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
608 McCabe Avenue | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA | | 16. Kind of Business/Industry
in home |
| | 17. Father's Name (First, Middle, Last)
Henry Grimes | | 18. Mother's Name (First, Middle, Maiden Surname)
Ollie Mae Brabham | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Charlcie Wallace | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21212 717 Ridgewood Avenue Baltimore, Maryland | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Voshell Mem. Gardens | | 20c. Location - City or Town, State
08-31-2000 Dundalk, MD |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. sepsis
Due to (or as a consequence of):
b. pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARRHYTHMIAS | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | |
| 28a. Date of Injury (Month, Day Year)
M | | | | | |
| 28b. Time of injury
1 Yes <input type="checkbox"/> No | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
M.D. | | | | | |
| 29c. License number
P14089 | | | | | |
| 29d. Date signed (Month, Day, Year)
AUGUST, 26, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ZOUFICAR KOBEISSI 5601 LOCH KAVEN BLVD BALTIMORE MD 21239 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | | |
| 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27192

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna Mary Gattus | | | | 2. Date of Death
Month Day Year
August 26, 2000 | | 3. Time of Death
11:55am | | |
| | 4a. Facility Name (If not institution, give street and number)
1201 Ridgeshire Rd. | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
215-09-6101 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 10, 1917 | | |
| | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 15. Decedent's Education (Specify only highest grade completed)
8 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Andrew Sopko | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Sopko Gattus | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John Gattus Jr. son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1201 Ridgeshire Rd. Dundalk, Md. 21222 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Mary | | 20c. Location - City or Town, State
Dundalk, Md | | 20d. Date
Aug 30, 2000 | |
| 21. Signature of Funeral Service Licensee
Anthony Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Rd. Dundalk, Md. 21222 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Non-Hodgkins Lymphoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
6mo | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Richard L. Lasky | | | | 29c. License number
D36814 | |
| | | | | 29d. Date signed (Month, Day, Year)
8/28/00 | | | | | |
| 30. Name and address of person who completed cause of death (last 23a) Type, Print)
1505 OLIVER DR. SUITE 302 TOWSON MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27193

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN S. GAWEN

2. Date of Death
Month Day Year
AUGUST 24 20003. Time of Death
1:50 am

4a. Facility Name (If not institution, give street and number)

GENESIS MULTI MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director5. Social Security Number
215-22-60936. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
84 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
08/06/19169. Birthplace (State or Foreign
Country)
MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7700 YORK RD.

10f. Zip Code

21204.

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12YRS

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

HOWARD SOYPHER (ATTORNY)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 NORTH CALVERT ST. BALTO., MD. 21202.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DRUID RIDGE CEM.

Date

08/30/2000

20c. Location - City or Town, State

PIKESVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Silent Arrhythmia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Minutes

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Arteriosclerotic Coronary Artery Disease

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, lecture, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D17118

29d. Date signed (Month, Day, Year)

Aug 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL SCHWARTZ M.D. 115 EAST MELROSE AVE. 21212.

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-5000.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 27194**
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|----|---------------------------|---|----|--------------------|----|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LARISA GRIGOREV | | | | 2. Date of Death
Month August Day 24 Year 2000 | | 3. Time of Death
3:25 PM | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-39-5883 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APR. 24 1951 | 9. Birthplace (State or Foreign Country)
UKRAINE | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
2442 FOREST GREEN ROAD | | | | 10f. Zip Code
21209 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER ASSISTANT | | | 16b. Kind of Business/Industry
EDUCATION | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
VLADIMIR MALAMENT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BRONISLAVA SOKOLOVSKAYA | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
EUGENE GRIGOREV/HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2442 FOREST GREEN ROAD BALTIMORE, MD. 21209 | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HAR SINAI CONGREGATION | | Date
8/27/00 | | 20c. Location - City or Town, State
OWINGS MILLS, MD. | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Scott M. Cottle | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS. INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>PULMONARY EMBOLISM</td> <td rowspan="4"> Approximate Interval Between Onset and Death

 6 hrs.

 4 years </td> </tr> <tr> <td>b.</td> <td>Astrocytoma</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | PULMONARY EMBOLISM | Approximate Interval Between Onset and Death

6 hrs.

4 years | b. | Astrocytoma | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | PULMONARY EMBOLISM | Approximate Interval Between Onset and Death

6 hrs.

4 years | | | | | | | | | | | | | | | |
| | b. | Astrocytoma | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Blumfeld MD | | | | 29c. License number
Res # 000 | | 29d. Date signed (Month, Day, Year)
August 24, 2000 | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
B. Acosta MD - Sinai Hospital of Baltimore, Maryland | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27195

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES J. GLOS JR

2. Date of Death

Month Day Year
AUGUST 24 2000

3. Time of Death

9:01 PM

4a. Facility Name (If not institution, give street and number)

5756 B CEDONIA AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-01-3695

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 26, 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5756 B. CEDONIA AVE

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

RUSSELL STEEL COMP.

17. Father's Name (First, Middle, Last)

JAMES J. GLOS, SR

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA ROBERTS

19a. Informant's Name/Relationship (Type, Print)

FRED GLOS (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9105 D Lincoln Shire CT. BALTO. MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

8/29/00

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME CATH.
7527 HARTFORD RD. BALTO. MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic PROSTATE CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD.

29c. License number

D 26434

29d. Date signed (Month, Day, Year)

8/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR SCHROEDER, MD. Hopkins AT White Marsh 4924 Campbell BLVD. BALTO. MD 21236

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,


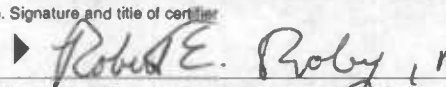
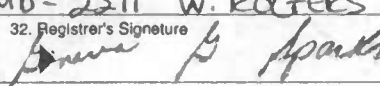
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27196

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY ANNE GENEVIEVE HEAGNEY | | | | 2. Date of Death
Month AUG Day 23 Year 2000 | | 3. Time of Death
1:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
THE WESLEY HOME, INC. | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
- | |
| Funeral
Director | 5. Social Security Number
212-38-0212 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT 16, 1910 | |
| | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | 10a. State
MD | | 10b. County
- | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2211 W. ROGERS AVE | | 10f. Zip Code
21209 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PROFESSOR | | 16b. Kind of Business/Industry
EDUCATION | | | | |
| 17. Father's Name (First, Middle, Last)
JOHN MATTHEW HEAGNEY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMMA BURGEOON | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PHILIP HEAGNEY, NEPHEW | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4541 GIBSON AVE. ST. LOUIS, MO. 63110 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVANS FUNERAL CHAPEL
BELAIR - P.A. | | 20c. Location - City or Town, State
FOREST HILL, MD | | 20d. Date
AUG 24 2000 | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
8800 HARFORD RD. PARKVILLE, MD. 21234 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY FAILURE
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA, ATRIAL FIBRILLATION,
RENAL INSUFFICIENCY | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D-19425 | | 29d. Date signed (Month, Day, Year)
AUG. 23, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT E. ROBY, MD - 2211 W. ROGERS BALTIMORE, MD. 21209 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#30 perDVR G786 8/29/2000 EW

Certificate of Death

Reg. No.

00 27197

| | | | | | | | | | | | |
|--|---|---|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LONDON B. HAYES | | | | 2. Date of Death
Month Day Year
AUGUST 16, 2000 | | | | 3. Time of Death
5:40 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
519 Aldersgate Court #505 | | | | 4b. City, Town, or Location of Death
Solomons | | | | 4c. County of Death
Calvert | | |
| Funeral
Director | 5. Social Security Number
536-26-6896 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 11, 1923 | | 9. Birthplace (State or Foreign Country)
VA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Calvert | | 10c. City, Town or Location
Solomons | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
519 Aldergate Ct #505 | | | | 10f. Zip Code
20688 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 Collegia (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
sales | | | | 16b. Kind of Business/Industry
unk | | | |
| 17. Father's Name (First, Middle, Last)
Fred Amos Hayes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nannie P. Shelton | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marcella Hayes/spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
519 Aldergate Ct #505 Solomons, MD 20688 | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | | | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | | |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. myelo proliferative disorder
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD
Coronary Artery disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and Title of Certifier
Joseph Barth | | | | 29c. License number
D0052242 | | | | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSEPH JOHN Barth Calvert Internal Med Group 110 Hospital Rd STE#310 Prince Frederick, MD 20678 | | | | | | | | | | | |
| 31. Date (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
Sparks | | | | | | | |


Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director


Medical Certification: To Be Completed by Physician/Medical Examiner

VOID

CERTIFICATE 

00-27198

SEE

CERTIFICATE 

99-42894

89-10-00

89-10-00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27199

| | | | | | | | |
|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SHARON L HART | | | | 2. Date of Death
Month Day Year
August 26 2000 | | 3. Time of Death
13:50 |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
218-26-3736 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | 8. Date of Birth (Month, Day, Year)
July 29, 1931 | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Baltimore | 10c. City, Town or Location
Middle River | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
202 Trailways Road | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | 16b. Kind of Business/Industry
Baltimore Pool Supply | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Elmer Melton | | | 18. Mother's Name (First, Middle, Maiden Surname)
Julietta Ryan | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Vaughan HART / husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
202 Trailways Road Baltimore MD 21220 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery | | Date
8/30/2000 | 20c. Location - City or Town, State
Baltimore MD | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD 21221 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
28 days |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
MCE | | | 29c. License number
D20907 | | 29d. Date signed (Month, Day, Year)
August 27, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marie Chatham MD, 9000 Franklin Square Drive, Baltimore, MD 21237 | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 25 2000 | | | 32. Registrar's Signature
B. Sparks | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27200

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|---|----|------------------------------|--|----|-------------|----|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>MURIEL Y. HANNIGAN</i> | | | | 2. Date of Death
Month Day Year
<i>April 24 2000</i> | | 3. Time of Death
<i>6:25pm</i> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Mariner Health Care</i> | | | | 4b. City, Town, or Location of Death
<i>Catonsville</i> | | 4c. County of Death
<i>Baltimore</i> | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>220-07-8223</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>95</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Mar. 12, 1905</i> | | 9. Birthplace (State or Foreign Country)
<i>MD</i> | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Catonsville</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
<i>98 Smithwood Ave.</i> | | | | 10f. Zip Code
<i>21228</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>9</i> College (1-4or 5+) <i></i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>John Tucker</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Unknown</i> | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Edward Hannigan, Sr.</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4 Colony Hill Court Arbutus, MD. 21227</i> | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Woodlawn Cemetery</i> | | Date
<i>8-28-00</i> | | 20c. Location - City or Town, State
<i>Baltimore, MD</i> | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus, MD. 21227</i> | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><i>Acute Pulmonary Edema</i></td> <td rowspan="4">Approximate Interval Between Onset and Death
<i>1 Day</i></td> </tr> <tr> <td>b.</td> <td><i>ASCD</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <i>Acute Pulmonary Edema</i> | Approximate Interval Between Onset and Death
<i>1 Day</i> | b. | <i>ASCD</i> | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <i>Acute Pulmonary Edema</i> | Approximate Interval Between Onset and Death
<i>1 Day</i> | | | | | | | | | | | | | | |
| | b. | <i>ASCD</i> | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia</i>
<i>hx Burchospasm</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
<i>D36942</i> | | 29d. Date signed (Month, Day, Year)
<i>August 25, 2000</i> | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>B. TORAKHIA, MD, 1009 Frederick Rd. Catonsville, MD 21228</i> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27201

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---------------------------------|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Conway Hayden</u> | | | | 2. Date of Death
Month <u>08</u> Day <u>25</u> Year <u>2000</u> | | 3. Time of Death
<u>1632</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>University of Maryland</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>213-34-4747</u> | | 6. Sex
<u>1</u> M <u>2</u> F | | 7. Age (In yrs. last birthday)
<u>61</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>Oct. 29, 1938</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Baltimore</u> | | 10c. City, Town or Location
<u>Edgemere</u> | |
| 10d. Inside City Limits
<u>1</u> Yes <u>2</u> No | | 10e. Street and Number
<u>2427 Lincoln Avenue</u> | | 10f. Zip Code
<u>21219</u> | | 10g. Citizen of What Country?
<u>United States</u> | | |
| 11. Marital Status
<u>1</u> Never Married <u>2</u> Married
<u>3</u> Widowed <u>4</u> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<u>1</u> Yes <u>2</u> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<u>1</u> Yes <u>2</u> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | |
| 15. Decedent's Education (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u>
<u>12 Years</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Electrician</u> | | 16b. Kind of Business/Industry
<u>Steel Industry</u> | | 17. Father's Name (First, Middle, Last)
<u>Conway S. Hayden, Sr.</u> | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Louise Carneal</u> | | 19a. Informant's Name/Relationship (Type, Print)
<u>Mrs. Elizabeth Hayden (Wife)</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2427 Lincoln Ave. Edgemere, Maryland 21219</u> | | 20a. Method of Disposition
<u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State
<u>4</u> Donation <u>5</u> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Holly Hill Mem. Gdns.</u> | | 20c. Date
<u>8/30/2000</u> | | 20d. Location - City or Town, State
<u>Middle River, MD</u> | | 21. Signature of Funeral Service Licensee
<u>C. Canall</u> | | |
| 22. Name and Address of Facility
<u>Duda-Ruck Funeral Home of Dundalk, Inc.</u>
<u>7922 Wise Ave. Dundalk, Maryland 21222</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>Intracerebral swelling from brain tumor</u>
Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
<u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | |
| 23d. Was an autopsy performed?
<u>1</u> Yes <u>2</u> No | | 23e. Were autopsy findings available prior to completion of cause of death?
<u>1</u> Yes <u>2</u> No | | 24. Was case referred to medical examiner?
<u>1</u> Yes <u>2</u> No | | 25. Place of Death (Check only one)
Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>8</u> Other (Specify) | | |
| 26. Manner of Death
<u>1</u> Natural <u>5</u> Pending Investigation
<u>2</u> Accident <u>6</u> Could not be determined
<u>3</u> Suicide <u>4</u> Homicide | | 27a. Date of Injury (Month, Day, Year)
<u>8/25/00</u> | | 27b. Time of Injury
<u>M</u> | | 27c. Injury at Work?
<u>1</u> Yes <u>2</u> No | | |
| 27d. Describe how injury occurred | | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 27f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28a. Certifier (Check only one)
<u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 28b. Signature and title of certifier
<u>[Signature]</u> | | 28c. License number
<u>11417643512457</u> | | 28d. Date signed (Month, Day, Year)
<u>8/25/00</u> | | 29. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>University of Maryland 22 S. Greene St Baltimore, Md 21201</u> | | |
| 30. Date filed (Month, Day, Year)
<u>AUG 29 2000</u> | | 31. Registrar's Signature
<u>[Signature]</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | 33. Registrar's Signature
<u>[Signature]</u> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27202

| | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Norman A. Habighurst, Jr. | | | | 2. Date of Death
Month Day Year
AUG 28 2000 | | 3. Time of Death
0002 | | |
| | 4e. Facility Name (If not Institution, give street and number)
ST. AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
216-16-6243 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 16, 1922 | | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2630 Washington Blvd. | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Steel Salesman | | 16b. Kind of Business/Industry
Sales | | | | | |
| 17. Father's Name (First, Middle, Last)
Norman A. Habighurst, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen J. Woods | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Phyllis E. Habighurst, wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2360 Washington Blvd. Baltimore, MD. 21230 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park | | 20c. Date
8-31-00 | | 20d. Location - City or Town, State
Elkridge, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus, MD. 21227 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrhythmia
Due to (or as a consequence of):
Acute Myocardial Infarction
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
P-13592 | | 29d. Date signed (Month, Day, Year)
Aug 28, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALEXANDER R. JOHNSON, M.D. ST. AGNES HOSPITAL, 900 CATON AVE, 21229 | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27203

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clara Marie Harbin

2. Date of Death

Month Day Year
Aug. 26 2000

3. Time of Death

11:25 am.

4a. Facility Name (If not institution, give street and number)

LongView Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

538-09-2234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 19, 1918

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2800 A Capehorn Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Louis Dufault

18. Mother's Name (First, Middle, Maiden Surname)

Alice Beaulaurier

19a. Informant's Name/Relationship (Type, Print)

Francis Harbin - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2800 A Capehorn Rd. Westminster, Md. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resthaven Mem. Gardens Aug. 29, 2000 Frederick, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. H. Eickhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 2110223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Eickhardt

29c. License number

10033677C

29d. Date signed (Month, Day, Year)

8/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steve Shuler 2111 Hannon Ave. Hagerstown MD 21204

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

J. H. Eickhardt

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 24a per verbal response G787 9/5/00 yf

Certificate of Death

Reg. No.

00 27204

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZA

HENDERSON

2. Date of Death
Month Day Year

Aug 26 2000

3. Time of Death
10pm

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

RANDALL TOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

250-36-7146

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Mar. 21 1926

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State
MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7402 LESADA DRIVE #3A

10f. Zip Code

21244

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

WILLIAM HENDERSON

18. Mother's Name (First, Middle, Maiden Surname)

HENRIETTA BOBB

19a. Informant's Name/Relationship (Type, Print)

WILLIAM E. CLARK - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 PINE CREEK DR. GREENVILLE, S.C. 29605

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BROWN ETHERNAL GARDENS

Date

9-3-00

20c. Location - City or Town, State

GREER, S.C.

21. Signature of Funeral Service Licensee

D. B. Harris

22. Name and Address of Facility

MARCH FUNERAL HOME WEST, INC.

4300 WABASH AVE. BALTO., MD

21215

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Chronic Obstructive Pulmonary Disease Unknown
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fib
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, tectory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

D. B. Harris MD

29c. License number

D27569

29d. Date signed (Month, Day, Year)

8/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen Hettelman 1838 Greene Tree Rd #300

State
Registrar

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

D. B. Harris

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

00 27205

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Monette Haigler | | | | 2. DATE OF DEATH
MONTH 08 DAY 22 YEAR 00 | | 3. TIME OF DEATH
9:30 AM | |
| 4. SOCIAL SECURITY NUMBER
219-98-1358 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
31 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
November 28, 1968 | |
| 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | | 9. COUNTY OF DEATH
Wicomico | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
303 Bridge Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Mardela Springs | | 9c. COUNTY OF DEATH
Wicomico | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Wicomico | | 10c. CITY, TOWN OR LOCATION
Mardela Springs | |
| 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
303 Bridge Street | | 10f. ZIP CODE
21837 | |
| 10g. CITIZEN OF WHAT COUNTRY?
United States | | | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
William A. Little | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Matilda R. Ayers | | | |
| 19a. INFORMANT'S NAME (Type/Print)
William A. Little/Father | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5320 Lantern Court, Baltimore, Maryland 21229 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | 20c. LOCATION — City or Town, State
8-26-00 Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Lisa S. Jefferson | | | | 22. NAME AND ADDRESS OF FACILITY
Loudon Park Funeral Home
3620 Wilkens Avenue, Baltimore, Maryland 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Dilated Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
b. Muscular Dystrophy Since Birth
DUE TO (OR AS A CONSEQUENCE OF):
c. Cerebrovascular accident, CVA
DUE TO (OR AS A CONSEQUENCE OF):
d. History of NonSustained Ventricular Tachycardia
Approximate Interval Between Onset and Death
years.
birth.
unknown. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acalculous Cholecystitis
Cachexia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28h. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Abne - K- Hamid, MD | | | | 29c. LICENSE NUMBER
DS2842 | | 29d. DATE SIGNED (Month, Day, Year)
08/22/00 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ASMA, AL-HAMID, 22137 Elm St; Prince Anne, MD 21853 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
AUG 29 2000 | | | | 32. REGISTRAR'S SIGNATURE
Beverly A. Sparks | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

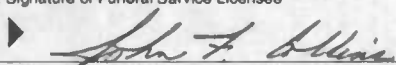
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27206

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|------------------------------|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Elaine Hemelt | | | | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
6:35 p.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
6854 Happy Heart Lane | | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard County | | |
| Funeral
Director | 5. Social Security Number
217-52-3448 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 18 1948 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Howard County | | 10c. City, Town or Location
Columbia | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
6854 Happy Heart Lane | | | | | 10f. Zip Code
21045 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | | 16b. Kind of Business/Industry
I.H.A.S. | | |
| 17. Father's Name (First, Middle, Last)
Harry Davis | | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Mildred Crozier | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William Hemelt III (Husband) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6854 Happy Heart Lane, Columbia, Md. 21045 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Data
8/28/00 | | 20c. Location - City or Town, State
Brooklyn Park, Md. | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
237 E. Patapsco Ave. Baltimore, Md. 21225 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>GLIOBLASTOMA, GRADE IV</u>
Due to (or as a consequence of):
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
8 MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D18587 | | 29d. Date signed (Month, Day, Year)
AUG 26 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL GORMLEY 900 CATON AVE BALTIMORE MD 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
 | | | | | | | |
| State Registrar | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

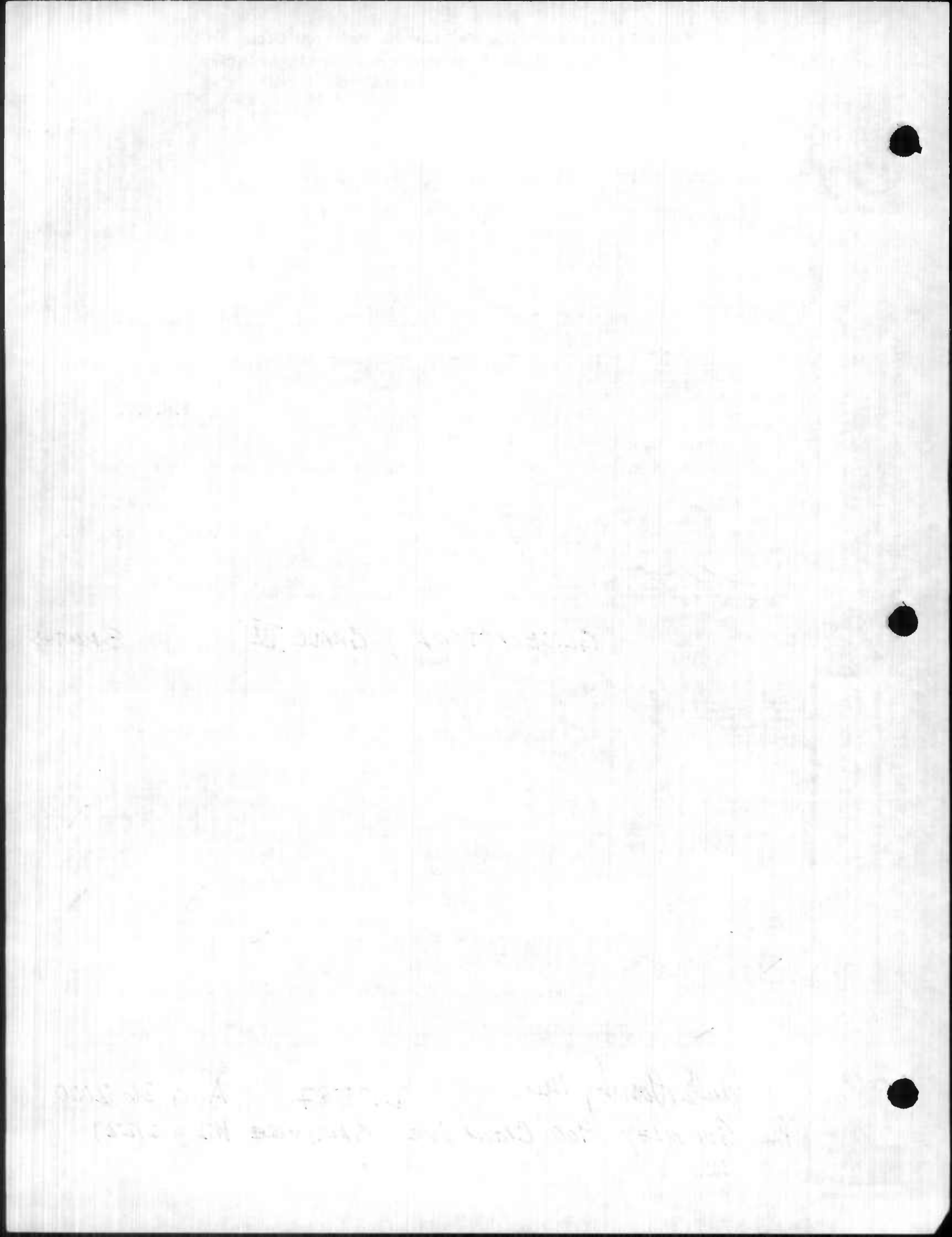
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27207

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|--|----------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James F. Hickman | | | | 2. Date of Death
Month Day Year
August 26 2000 | | 3. Time of Death
11:37 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Gilchrist Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
236-50-5519 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JUNE 17, 1933 | | 9. Birthplace (State or Foreign Country)
West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4020 Augustine Lane | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1952-1960 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
Factory | | |
| 17. Father's Name (First, Middle, Last)
Stewart Hickman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bernice Chapman | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Melanie Gochnour/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7859 St. Claire La. Baltimore, MD 21222 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | Date
8-28-00 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Thomas Gregor | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <u>gastric cancer</u>
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
4 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Anthony Riley MD | | | | 29c. License number
D25225 | | 29d. Date signed (Month, Day, Year)
August 27, 2000 | | |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)
W.A. Riley, Jr. 6701 N. Charles St. Balto. md 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
Benjamin B. Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27208

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IDA HYTOVITZ | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
5:30 P |
| | 4e. Facility Name (If not institution, give street and number)
LEVINDALE HEBREW HOME | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
209-10-5561 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
JAN. 20, 1916 | | 9. Birthplace (State or Foreign Country)
PA | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
2500 W. BELVEDERE AVENUE #413 | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) BOOKKEEPER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
MANUFACTURING COMPANY | |
| 17. Father's Name (First, Middle, Last)
PHILLIP GARBER | | | 18. Mother's Name (First, Middle, Maiden Surname)
SCPHIA (UNKNOWN) | | |
| 19a. Informant's Name/Relationship (Type, Print)
LEON HYTOVITZ / HUSBAND | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
2500 W. BELVEDERE AVE. #413 - BALTIMORE, MD 21215 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CHIZUK AMUNO | | 20c. Location - City or Town, State
8/27/00 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Cerebrovascular Accidents
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
Same day | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of): | | years | |
| | | c. Hypertension
Due to (or as a consequence of): | | years | |
| | | d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| Pressure Sores | | | | | |
| Parkinson's Disease | | | | | |
| Rheumatoid Arthritis | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D23767 | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Debra S. Weithamer MD, 2434 W. Belvedere Ave, Balto, MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | |

ORIGINAL

10/20/1918

Received of the
United States
Treasury

Five hundred
dollars
for the
use of the
Department of
the Interior

For the purchase of
land in the
State of
California

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27209

| | | | | | |
|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MINNIE HETTLEMAN | | 2. Date of Death
Month AUGUST Day 25 Year 2000 | | 3. Time of Death
2:35 PM |
| | 4a. Facility Name (If not institution, give street and number)
BRIGHTWOOD NURSING HOME | | 4b. City, Town, or Location of Death
LUTHERVILLE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
219-22-0342 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
NOV. 20, 1906 | | 9. Birthplace (State or Foreign Country)
MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
BALTIMORE |
| | 10c. City, Town or Location
LUTHERVILLE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
515 BRIGHTFIELD ROAD | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: COAST GUARD | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER |
| | 17. Father's Name (First, Middle, Last)
BENJAMIN HETTLEMAN | | 18. Mother's Name (First, Middle, Maiden Surname)
JENNIE HETTLEMAN | | 19. Informant's Name/Relationship (Type, Print)
MILTON HETTLEMAN / BROTHER |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH HAMEDROSH HAGODAL | | 20c. Location - City or Town, State
ROSEDALE, MD |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SCL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
CARDIOMYOPATHY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
END STAGE DEMENTIA
HYPERTENSION | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier

SHALINI TEWARI, M.D. | | 29c. License number
D52671 | |
| 29d. Date signed (Month, Day, Year)
AUGUST 25, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHALINI TEWARI, M.D. 1838 GREENTREE ROAD #300 - PIKESVILLE, MD 21208 | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27210

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Deborah Johnson</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>21</i> Year <i>2000</i> | | | | 3. Time of Death
<i>1:00 a.m.</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>6726 Yataruba Drive</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | | | 4c. County of Death
<i>NA</i> | | |
| Funeral
Director | 5. Social Security Number
<i>129-32-5732</i> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>57</i> Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 8. Date of Birth
(Month, Day, Year)
<i>11-19-1942</i> | | 9. Birthplace (State or Foreign Country)
<i>AL</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town or Location
<i>Baltimore</i> | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
<i>6726 Yataruba Drive</i> | | | | 10f. Zip Code
<i>21207</i> | | | | 10g. Citizen of What Country?
<i>U.S.A</i> | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>Master</i> | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>Teacher</i> | | | | 16b. Kind of Business/Industry
<i>School</i> | | | |
| 17. Father's Name (First, Middle, Last)
<i>Dan Bell</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Ethel Jackson</i> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Russell Johnson - Husband</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>6726 Yataruba Drive Baltimore MD 21207</i> | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Garrison Forest Vet</i> | | | | Date
<i>8-25-00</i> | | 20c. Location - City or Town, State
<i>Owings Mills, MD</i> | |
| 21. Signature of Funeral Service Licensee
<i>Ada March</i> | | | | 22. Name and Address of Facility
<i>March F.A. West
4300 Wabash Avenue Baltimore, MD 21215</i> | | | | | | | |
| Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. <i>Endometrial Cancer</i>
Due to (or as a consequence of): | | | | | | | | | | | |
| b. Due to (or as a consequence of): | | | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>above metastatic to Liver / Pleural effusions</i> | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Scott R. Rife</i> | | | | 29c. License number
<i>D34145</i> | | | | 29d. Date signed (Month, Day, Year)
<i>Aug 22, 2000</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Scott R. Rife 21 Crossroads Dr Owings Mills MD 21117</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | | | 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27211

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anne Catherine Kitson | | | | 2. Date of Death
Month: August Day: 24 Year: 2000 | | 3. Time of Death
8:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Gilchrist Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-38-4586 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 18, 1939 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by
Funeral Director | 10e. Street and Number
737 Highwood Dr. | | | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| To Be Completed by
Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
clerical | | 16b. Kind of Business/Industry
telephone company | |
| | 17. Father's Name (First, Middle, Last)
Thomas James Kitson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Catherine Madigan | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Riefner (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3514 Ailsa Avenue Baltimore, Maryland 21214 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
8/28/00 | |
| To Be Completed by
Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
George Ferran | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd.
Baltimore, MD 21212 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.)
Immediate Cause (Final disease or condition resulting in death)
a. uterine cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
month | | | |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
W.A. Riley, M.D. | | | |
| To Be Completed by
Physician/Medical Examiner | 29c. License number
D25245 | | | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
W.A. Riley, M.D. 6761 N. Charles St. Balto MD 21204 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
Denise B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27212

| | | | | | | | | |
|---|---|---------------------------|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Isabel B. Kelly | | | | 2. Date of Death
Month Day Year
August 28, 2000 | | 3. Time of Death
12:45PM | |
| | 4a. Facility Name (If not institution, give street and number)
St. Elizabeth's Nursing Home | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-01-0648 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT 27, 1909 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
3320 Benson Avenue | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Insurance Company | | |
| 17. Father's Name (First, Middle, Last)
Emmett Blackburn | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frances Elizabeth Davis | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Frances L. Burl/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
715 Maiden Choice Lane, PV311 Catonsville, MD 21228 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Edward A. Gregorchik | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | |
| a. Cerebrovascular Accident 5 minutes | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| b. Cerebrovascular Insufficiency 20 years | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| c. Generalized Atherosclerosis 30 years | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| d. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY HEART DISEASE. Peripheral Arterial Insufficiency. Ischemic ulcers both legs. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Attending | | | | 29c. License number
D16200 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. M. M. WACHMAN 720-C MAIDEN CHOICE LA., CATONSVILLE, 21228 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
B. Spauls | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27213

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Louis Lazzati | | | | 2. Date of Death
Month: August Day: 24 Year: 2000 | | 3. Time of Death
3:19 PM | |
| | 4a. Facility Name (If not institution, give street and number)
3704 N. Charles Street #504 | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
216-01-5263 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3704 N. Charles Street | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner | | 16b. Kind of Business/Industry
Construction | | | | |
| 17. Father's Name (First, Middle, Last)
James Lazzati | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Ertola | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John L. Lazzati, Jr. (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13710 Manda Mill Lane Phoenix, Maryland 21131 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Gardens | | 20c. Date
8/28/00 | | 20d. Location - City or Town, State
Timonium, Maryland | | |
| 21. Signature of Funeral Service Licensee
Steven T. Bittel | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic End Stage Small Cell Cancer of the Lung
Due to (or as a consequence of):
b. Congestive Heart Failure
Due to (or as a consequence of):
c. Metastasis to Brain, Bone
Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
for Richard H. Hyslop, M.D.
JAI H. JOCHI, M.D. | | | | | | 29c. License number
D-26600 | | |
| 29d. Date signed (Month, Day, Year)
August 25, 2000 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John C. Downs, M.D. 7505 Osler Drive Suite 302 Towson, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | | | | |

ORIGINAL

1. The first of these is the
fact that the system is
not a simple one.

2. The second is the fact that the
system is not a simple one.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27214

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE L. LLOYD

2. Date of Death

Month Day Year
August 23, 2000

3. Time of Death

11:00 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

217-26-2854

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 13, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3721 Ina Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs.

College (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Type Setter

16b. Kind of Business/Industry

Essex Community College

17. Father's Name (First, Middle, Last)

Herbert Leroy Ridgley

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Christ

19a. Informant's Name/Relationship (Type, Print)

Mr. Marlin W. Lloyd (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30493 Dagsboro Rd. Salisbury, Md. 21804

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc. 8-26-2000

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Donald C. Lassahn

22. Name and Address of Facility

Lassahn Funeral Home
7401 Belair Rd. Baltimore, Md. 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Congestive Heart Failure*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD
Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

DS9813

29d. Date signed (Month, Day, Year)

8/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Atkins 1104 Wendellway Drive, Salisbury MD 21804

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Marjorie Lee Lloyd
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27215

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGARET E. Minton | | | | | | 2. Date of Death
Month Day Year
August 22, 2000 | | 3. Time of Death
11:45 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
ARMACOST NURSING HOME | | | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
213-74-5039 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
97 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug 26, 1902 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2905 LINWOOD AVE. | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 YRS. College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
AT HOME | | | |
| | 17. Father's Name (First, Middle, Last)
VALENTINE WEIS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET KRIEL | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Bonnie Beall | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
617 RADWINO LIRCH LOCKEYSVILLE, MARYLAND 21030 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MORLAND MEM PARK | | 20c. Location - City or Town, State
PARKVILLE, MARYLAND | | 20d. Date
Aug 25, 2000 | | | | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | | | 22. Name and Address of Facility
EVAN CHAPEL OF MEMORIES 21234
8800 HARFORD ROAD PARKVILLE, MARYLAND | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
Year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
[Signature] | | | | | | 29c. License number
Q-17041 | | 29d. Date signed (Month, Day, Year)
August 23, 2000 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark I. Leary MD 41205 YORK ROAD STE 38 LUTHERVILLE MD 21093 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27216

Replacement

| | | | | | |
|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Helen</i> | | 2. Date of Death
Month <i>August</i> Day <i>19</i> Year <i>2000</i> | | 3. Time of Death
<i>04:44am</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>University of Maryland Medical System</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> |
| Funeral
Director | 5. Social Security Number
<i>136-18-7619</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>78</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>JUNE 13, 1922</i> | 9. Birthplace (State or Foreign Country)
<i>New Jersey</i> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | 10b. County
<i>N/A</i> | 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
<i>611 South Charles Street</i> | | 10f. Zip Code
<i>21230</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> |
| | 17. Father's Name (First, Middle, Last)
<i>UNK.</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>UNK.</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Gabriel Conrad Suggs/Son</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>309 Lord Byron Lane Cockeysville, MD 21030</i> | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Metro Crematory Inc.</i> | | 20c. Location - City or Town, State
<i>Baltimore, MD</i> |
| | 21. Signature of Funeral Service Licensee
<i>Thomas Gregor</i> | | 22. Name and Address of Facility
<i>Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228</i> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Cardiac Arrhythmia</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) <i></i> 28b. Time of Injury <i>M</i> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred <i></i> 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i></i> 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i></i> | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>Walter Belk</i> | | | | | |
| 29c. License number
<i>D46612</i> | | | | | |
| 29d. Date signed (Month, Day, Year)
<i>October 18, 2000</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Walter Belkera -- 22 South Greene St., Baltimore, Maryland 21201</i> | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 00058.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27217

| | | | | | | | | |
|--|---|--|---|---------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carl H. Michelman, Jr. | | | | 2. Date of Death
Month Day Year
August 28, 2000 | | 3. Time of Death
12:14 AM | |
| | 4a. Facility Name (If not institution, give street and number)
7 Shelby's Path Apt. E | | | | 4b. City, Town, or Location of Death
Sparks | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
219-38-2295 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 9, 1941 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore Co. | | 10c. City, Town or Location
Sparks | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
7 Shelby's Path Apt. E | | | |
| | 10f. Zip Code
21152 | | | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Customer Service Manager | | 16b. Kind of Business/Industry
Chrysler | | | |
| | 17. Father's Name (First, Middle, Last)
Carl Henry Michelman, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mildred V. Dorsey | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Mary L. Michelman / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Shelby's Path Apt E Sparks, Maryland 21152 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | 20c. Date
9/1/2000 | | 20d. Location - City or Town, State
Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee
Michael E. Canapp | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, MD 21214 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| State Registrar | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
G.I. Ch | | | | 29c. License number
D27730 | | 29d. Date signed (Month, Day, Year)
8/28/00 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GARY COOK, JR. 6569 N. SPARKS ST. BALTO. MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27218

| | | | | | | | | | |
|---|---|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RUTH McGUIRE | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | 3. Time of Death
5:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Hammonds Lane Genesis Eldercare | | | | 4b. City, Town, or Location of Death
Brooklyn Park | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
218-44-3207 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
1/24/1915 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Anne Arundel | | 10c. City, Town or Location
Odenton | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
2408 Autumn Harvest Ct., Apt. 201 | | | | 10f. Zip Code
21113 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collega (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Sigmond Reckline | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jennifer Burger | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Margaret Martel | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2408 Autumn Harvest Ct., #201, Odenton, MD 21113 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial PK 8/30 | | 20c. Location - City or Town, State
Glen Burnie, MD | | | | |
| | 21. Signature of Funeral Service Licensee
Kelly Gregory Fink | | | | 22. Name and Address of Facility FINK FUNERAL HOME, PA
426 Crain Hwy., SW, Glen Burnie, MD 21061 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colon Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
DS3462 | | 29d. Date signed (Month, Day, Year)
8/29/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jude Muneses MD 7845 Oakwood Road Glen Burnie MD 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#20a,22 perFHG786 8/29/2000 EW

Certificate of Death

Reg. No. 00 27219

| | | | | | | | | |
|---|---|--|--|---|--|--------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Barry J. Mackall | | | | 2. Date of Death
Month Day Year
August 27 2000 | | 3. Time of Death
3:10 am | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital
Baltimore, MD 21229 | | | | 4b. City, Town, or Location of Death
Baltimore, MD | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
213-52-1240 | | 6. Sex
M <input checked="" type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday)
52 Yrs. | | 8. Date of Birth (Month, Day, Year)
3 31 1948 | |
| | 9. Birthplace (State or Foreign Country)
Md | | 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
6634 Eberle Drive | | 10f. Zip Code
21215 | |
| | 10g. Citizen of What Country?
U S A | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
GED 12th grade N/A | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Landscaper | | | | 16b. Kind of Business/Industry
Myers Seen Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Bullock | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Mackall | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Dorothy Livers- Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6634 Eberle Drive Apt 202 Baltimore, Md 21215 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
Catonsville, MD | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
March West
4300 Wabash Ave, Balto, Md 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <u>Sepsis</u>
Due to (or as a consequence of):
b. <u>AIDS</u>
Due to (or as a consequence of):
c. <u>ESRD</u>
Due to (or as a consequence of):
d. <u>Hepatitis C</u> | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Hypertensive cardiovascular disease, HTN</u>
<u>HIV dementia, anemia, IVDA</u> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<u>Sahar Younis, M.D.</u> | | | | |
| 29c. License number | | | | 29d. Date signed (Month, Day, Year)
August 27, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Sahar Younis 410 NARGONNE AVE Sterling, VA 20164</u> | | | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | 33. State Registrar
DHMH 16 Rev 5/95 | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27220

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | |
|---|---|----------------------------------|---|---|--|----------------------|--|--|---|---|-----------------------------------|----------------------------------|--|------------------------------|----------------------------------|----------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Mamie Mackel</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>9</i> Year <i>2000</i> | | | | 3. Time of Death
<i>9:23 AM</i> | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>University of Maryland Medical Systems</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | | | 4c. County of Death
<i>NA</i> | | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>219-10-1333</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>76</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Oct 2 1923</i> | | 9. Birthplace (State or Foreign Country)
<i>S.C.</i> | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 10e. Street and Number
<i>3925 WOODRIDGE ROAD</i> | | | | 10f. Zip Code
<i>21229</i> | | | | 10g. Citizen of What Country?
<i>U SA</i> | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>NA</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>CABLE ASSEMBLER</i> | | | | 16b. Kind of Business/Industry
<i>WESTINGHOUSE ELECTRIC CORP.</i> | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>WILLIAM M. LOWRY</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>VANCIA STARNES</i> | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>FRANCES GARNER-GODDAUGHTER</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3 NEWBRIDGE COURT BALTIMORE MD 21133</i> | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>KING MEMORIAL PARK</i> | | | Date
<i>83100</i> | | 20c. Location - City or Town, State
<i>Randallstown, MD</i> | | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Theresa B. Starnes</i> | | | | | 22. Name and Address of Facility
<i>MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE. BALTO., MD 21215</i> | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Cardiovascular Collapse</i></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Pulmonary Embolism</i></td> </tr> <tr> <td>c. <i>Deep Venous Thrombosis</i></td> </tr> <tr> <td>d. _____</td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <i>Cardiovascular Collapse</i> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. <i>Pulmonary Embolism</i> | c. <i>Deep Venous Thrombosis</i> | d. _____ |
| Immediate Cause (Final disease or condition resulting in death) | a. <i>Cardiovascular Collapse</i> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | |
| | b. <i>Pulmonary Embolism</i> | | | | | | | | | | | | | | | |
| | c. <i>Deep Venous Thrombosis</i> | | | | | | | | | | | | | | | |
| | d. _____ | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Theresa B. Starnes</i> | | | | | 29c. License number
<i>AU4176435R12450</i> | | 29d. Date signed (Month, Day, Year)
<i>08/20/00</i> | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>BIMAC RAMI 22 South Greene Street, Baltimore, Maryland 21201</i> | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | | | | 32. Registrar's Signature
<i>Beverly B. Sparks</i> | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27221

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Lee Floyd Myers

2. Date of Death

August 23 2000

3. Time of Death

1149

4a. Facility Name (If not institution, give street and number)

Washington Co. General Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

213-26-7970

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan 8, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

615 Cleveland Road

10f. Zip Code

21090

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Butler Aviation Co.

17. Father's Name (First, Middle, Last)

Stanley Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Emma Stevens

19a. Informant's Name/Relationship (Type, Print)

Edward Earl Myers, Jr.-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 Cleveland Rd., Linthicum, Md. 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Pk. 8/25/00 Glen Burnie, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

237 E. Patapsco Ave., Baltimore, Md. 21225-1856

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

< 1 hour

20 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Max Byrkit MD

29c. License number

D000936

29d. Date signed (Month, Day, Year)

August 23 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Max Byrkit MD

3 Byrkit Dr Williamsport Md 21795

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Benjamin G Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Virginia Myers

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27222

| | | | | | | | | | |
|--|---|---|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen Louise Matusky | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
12:00 Noon | | |
| | 4a. Facility Name (If not institution, give street and number)
St. Elizabeth's Nursing Home | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | | |
| Funeral
Director | 5. Social Security Number
216-18-6965 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 26, 1924 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Baltimore County | | 10c. City, Town or Location
Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
3234 Ryerson Circle | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6
College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home Owner | | 17. Father's Name (First, Middle, Last)
George Jones | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Selway | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary C. Dorsey (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1043 Old Manchester Road, Westminster, Md. 21157 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | 20c. Date
8/28/2000 | | 20d. Location - City or Town, State
Baltimore, Md. | | | |
| 21. Signature of Funeral Service Licensee
Christina L. Hilton | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave. Baltimore, Md. 21230 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | a. Electrolyte Imbalance
Due to (or as a consequence of): | | b. Starvation
Due to (or as a consequence of): | | c. Dementia
Due to (or as a consequence of): | | d.
Due to (or as a consequence of): | |
| Approximate Interval Between Onset and Death
few days
few weeks
several yrs | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Depression
Hypertension
Chronic Urinary Tract Infection | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Aug 24 2000 | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Geetha Raju | | 29c. License number
DA7541 | |
| 29d. Date signed (Month, Day, Year)
August 25, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEETHA RAJA 4367 Hollins Ferry Rd, Baltimore MD 21227 | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27223

| | | | | | |
|---|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GRACE MERSON | | 2. Date of Death
Month AUGUST Day 29 Year 2000 | | 3. Time of Death
3:40AM |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
n/a |
| Funeral
Director | 5. Social Security Number
219-10 2208 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Sept. 18 1910 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Md. | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
1522 Belt Street | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home Owner | |
| 17. Father's Name (First, Middle, Last)
Will Haynes | | | 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Duvall | | |
| 19a. Informant's Name/Relationship (Type, Print)
Evelyn Heck (Daughter) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1522 Belt Street, Baltimore, Md. 21230 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Cemetery | | 20c. Location - City or Town, State
8/31/2000 Damascas, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave. Baltimore, Md. 21230 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. SEPSIS
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
2 DAYS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | b. IMMUNOCOMPROMISE
Due to (or as a consequence of): | | 15 DAYS | |
| | | c. END STAGE RENAL DISEASE
Due to (or as a consequence of): | | 1 YEAR | |
| | | d. DIABETES MELLITUS
Due to (or as a consequence of): | | 25 YEARS | |
| | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, CORONARY ARTERY DISEASE,
HYPOTHYROIDISM | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
AS 2441614-A55 | | 29d. Date signed (Month, Day, Year)
AUGUST 29, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GUILLERMO GIANGRECO 3001 SOUTH HANOVER ST, BALTIMORE, MD 21225 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27224

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THALIA D. MOLER | | 2. Date of Death
Month August Day 27 Year 2000 | | 3. Time of Death
8:50 PM |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
219-20-2260 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | 8. Date of Birth (Month, Day, Year)
JULY 23, 1926 |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | | | |
| To Be Completed by
Funeral Director | Usual Residence of Decedent | | 10a. State
MD. | | 10b. County
BALTIMORE |
| | 10c. City, Town or Location
DUNDALK | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
6915 SOLLERS POINT RD. | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U. S. A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| To Be Completed by
Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME |
| | 17. Father's Name (First, Middle, Last)
CLARK S. McGAHA | | 18. Mother's Name (First, Middle, Maiden Surname)
EDITH L. SNOOTS | | |
| | 19a. Informant's Name/Relationship (Type, Print)
A. RICHARD MOLER /husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6915 SOLLERS POINT RD. BALTO. MD 21222 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEADOWRIDGE CCM | | 20c. Location - City or Town, State
8/31/00 ELK RIDGE, MD. |
| | 21. Signature of Funeral Service Licensee
Anthony Connelly | | 22. Name and Address of Facility
CONNELLY Funeral Home of Dundalk, P.A.
7100 SOLLERS POINT Rd Dundalk Md. 21222 | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Chronic obstructive Pulmonary Disease | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Chi-Shiang Chen MD | | 29c. License number
0-18151 | 29d. Date signed (Month, Day, Year)
8/27/2000 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Chi-Shiang Chen 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
Bene G. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

GABRIELLE McLEAN

amend item 23a, b, c, 27, 28a, b, c, d, ef, per me 37801-00/000rf

AMEND ITEMS: #23 PART I, 28 PER MEO

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27225

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gabrielle R McLean | | | 2. Date of Death
Month Day Year
AUG. 25, 2000 | | 3. Time of Death
0706 AM | |
| | 4a. Facility Name (If not institution, give street and number)
BON SECOUR HOSPITAL | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-98-5484 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
21 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 28, 1978 |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
2003 Rayner Ave | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House Keeper | | 16b. Kind of Business/Industry
Sheraton Hotel | |
| 17. Father's Name (First, Middle, Last)
Joe-Nathan McLean | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Watkins | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Watkins McLean/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2003 Rayner Ave. Baltimore, MD 21217 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery Aug. 31, 2000 Baltimore, MD | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CALVIN B SCRUGGS FUNERAL HOME
1412 E PRESTON STREET BALTO. MD 21213 | | | |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
HEMOPERITONEUM DUE TO A RUPTURED SPLEEN IN ASSOCIATION WITH A SEIZURE DISORDER | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
8/25/00 | | 28b. Time of Injury
A M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
subject experienced seizure | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2003 Raynor Avenue Baltimore, Maryland | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier

MARY C. RIPLE M.D. | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
AUG. 26, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY C. RIPLE M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27226

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Irvin Moats

2. Date of Death
Month Day Year

August 23, 2000

3. Time of Death

9:02 a.m.

4a. Facility Name (If not institution, give street and number)

13834 Hollow Road

4b. City, Town, or Location of Death

Hancock

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

167-14-5185

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 3, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hancock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13834 Hollow Road

10f. Zip Code

21750

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tow Motor Operator

16b. Kind of Business/Industry

Aircraft Manufacture

17. Father's Name (First, Middle, Last)

Dallas Moats

18. Mother's Name (First, Middle, Maiden Surname)

Alice McLucas

19a. Informant's Name/Relationship (Type, Print)

Lee Esta Jenkins/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18621 Breathedsville Road Boonsboro, MD 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Stone Bridge Cemetery

Date

08/26/2000

20c. Location - City or Town, State

Hancock, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Grove Funeral Home, P.A.

141 W. Main St. Hancock, MD 21750-0368

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Bronchogenic Carcinoma
Due to (or as a consequence of):
b. Of the lungs
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 years

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obliterative Peripheral Vessel
disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

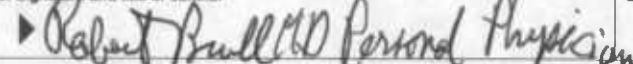
27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 Robert Bull MD Personal Physician

29c. License number

DO 4359

29d. Date signed (Month, Day, Year)

8/23/00


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT BULL 1459 Potomac Ave Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27227

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD E. NAUGLE

2. Date of Death

Month Day Year
August 25 2000

3. Time of Death

02:40 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

091-18-7286

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 26, 1913

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane HR 439

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

quality controller

16b. Kind of Business/Industry

pharmaceutical

17. Father's Name (First, Middle, Last)

George Naugle

18. Mother's Name (First, Middle, Maiden Surname)

Ida Stalter

19a. Informant's Name/Relationship (Type, Print)

St. Agnes Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 S. Caton Avenue Baltimore, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic obstructive pulmonary disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hwan Yoo, M.D.

29c. License number

D0053514

29d. Date signed (Month, Day, Year)

August 25 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hwan Y. Yoo, M.D., St. Agnes Hospital

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

[Signature]

State
Registrar

Richard Naugle
Baltimore, Maryland 21215-0020

NAME
NAUGLE Richard
Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

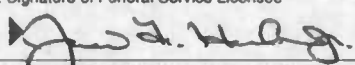


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27228

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Leo | | 2. Date of Death
Month August Day 26 Year 2000 | | 3. Time of Death
5:55 AM |
| | 4a. Facility Name (If not institution, give street and number)
The Johns Hopkins Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
220-01-2263 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 | 8. Date of Birth (Month, Day, Year)
April 24, 1918 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
9460 Joppa Pond Road | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade
College (1-4 or 5+) -0- | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Admissions Manager | | 16b. Kind of Business/Industry
Maryland Horse Racing | | |
| | 17. Father's Name (First, Middle, Last)
Solomon Nechamkin | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma M. Hiel | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lynn Gisriel - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9460 Joppa Pond Road; Baltimore, Maryland 21234 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Family Cemetery | | 20c. Location - City or Town, State
08/29/2000 Randallstown, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
M00869 8728 Liberty Road; Randallstown, Maryland 21133 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Subarachnoid Hemorrhage | | Approximate Interval Between Onset and Death
One Month |
| | Due to (or as a consequence of): | | b. Ruptured Cerebral Aneurysm | | One Month |
| | Due to (or as a consequence of): | | c. | | |
| | Due to (or as a consequence of): | | d. | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
August 26, 2000 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Solomon Nechamkin 9460 Joppa Pond Road Baltimore | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27229

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|---|--|--------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred I. Nardone | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
8:25 am |
| | 4a. Facility Name (If not institution, give street and number)
5162 Down West Ride | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard |
| Funeral
Director | 5. Social Security Number
213-07-0656 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Jan. 25, 1918 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Md. | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | |
| 10e. Street and Number
5162 Down West Ride | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Yrs. College (1-4 or 5+) 8 Yrs. | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Hairdresser | | 16b. Kind of Business/Industry
Cosmetology | | | |
| 17. Father's Name (First, Middle, Last)
Jacob Jaworski | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Arvey | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jackie Short daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3711 Shateau Ridge Dr. Ellicott City 21042 | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
Catonsville, Md. | |
| 21. Signature of Funeral Service Licensee
Anthony Connelly | | 22. Name and Address of Facility
Connolly Funeral Home of Dundalk, P.A.
7110 Sollers Point Rd. Dundalk, Md. 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Heart Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
William Flowers M.D. | | 29c. License number
D20789 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Flowers M.D. 11055 Little Patuxent Columbia Md | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27230

| | | | | | | | | | | |
|---|--|---|--|--|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELIZABETH M. O'BRIEN | | | | | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
6:50 pm | |
| | 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital | | | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
215.32.8372 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
95 Yrs. | | 8. Date of Birth (Month, Day, Year)
SEPT 14 1904 | | 9. Birthplace (State or Foreign Country)
PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
GLEN BURNIE | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
1205 KIMBERLY LN | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURSE | | | 16b. Kind of Business/Industry
MERCY HOSPITAL | | | |
| 17. Father's Name (First, Middle, Last)
ANDREW KLENOTIZ | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BARBARA HUJUS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ELIZABETH FIEDLER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1205 KIMBERLY LN GLEN BURNIE, MD 21061 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BAYVIEW CREMATORY | | Date
8.28.00 | | 20c. Location - City or Town, State
BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee
K. GREGORY FINK | | | | 22. Name and Address of Facility
FINK FUNERAL HOME P.A.
426 CRAIN HWY S GLEN BURNIE MD 21061 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of): | | | | | | | | | | |
| b. Drabator
Due to (or as a consequence of): | | | | | | | | | | |
| c. Atrial fibrillation
Due to (or as a consequence of): | | | | | | | | | | |
| d. | | | | | | | | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Lynn R. mrs | | | | 29c. License number
D25654 | | 29d. Date signed (Month, Day, Year)
Apr/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YEONG OH 1477 Crain Hwy N G.D MD 21061 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

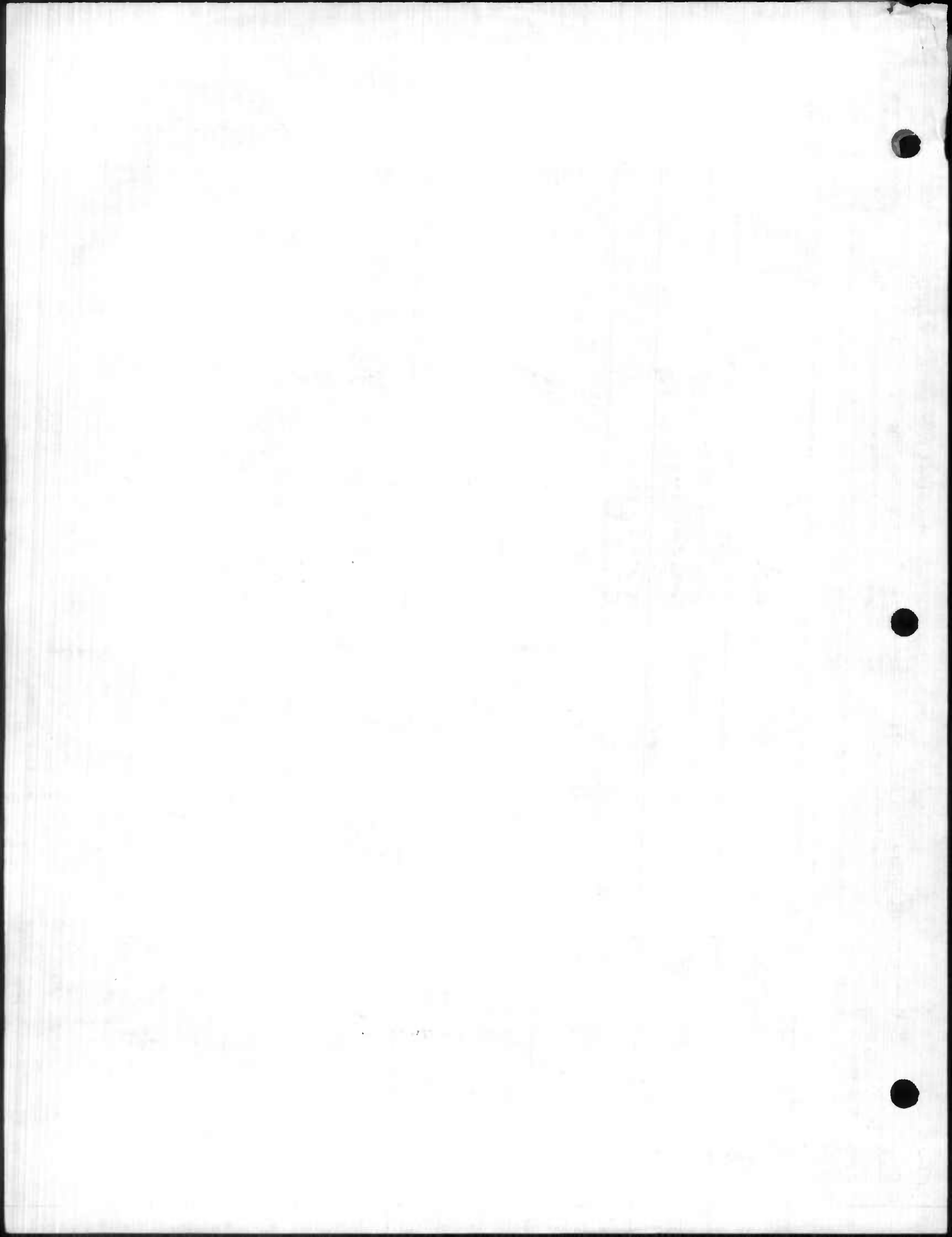
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27231

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Isobel Owen | | | | 2. Date of Death
Month August Day 27 Year 2000 | | | | 3. Time of Death
12:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Harmony Hall | | | | 4b. City, Town, or Location of Death
Columbia | | | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
526-48-8945 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 13, 1917 | | 9. Birthplace (State or Foreign Country)
England | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
6336 Cedar Lane Apt# 331 | | | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | |
| | 17. Father's Name (First, Middle, Last)
Arthur Bowley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith Hawksley | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Virginia A. Parker/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6019 Jacobs Ladder Columbia, MD 21045 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | Date
8-28-00 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
Thomas Gregor | | | | 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
months | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted Living | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
Kevin Carlson | | | | 29c. License number
D-53636 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KEVIN CARLSON 3160 Elliott Center Drive Elliott City MD 21043 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
Kevin Carlson | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27232

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWIN HEBDEN PERKINS, Jr. | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | 3. Time of Death
3:45 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Gilchrist Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-05-2675 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 9, 1917 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3219 Berkshire Road | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Certified Public Accountant | | 16b. Kind of Business/Industry
Utilities | | | | |
| | 17. Father's Name (First, Middle, Last)
Edwin Hebden Perkins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marian Marie Baumgarten | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Victoria Perkins (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30 Atherton Road Lutherville, Maryland 21093 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
9-1-00 | | |
| | 21. Signature of Funeral Service Licensee
George J. Ferrante | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aortic stenosis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
years | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Hospice | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Anthony Riley, MD | | | | 29c. License number
D25205 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
W.A. Riley 68701 N. Charles St. Balto. md 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27233

Amended item #15 per FH G787 9-5-00 WJJ

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Paul George Pratt | | | | 2. Date of Death
Month Day Year
August 24 2000 | | 3. Time of Death
11:45 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
700 Wyndhurst Avenue | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | |
| Funeral
Director | 5. Social Security Number
215-24-8904 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
February 12 1929 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent
10a. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yea 2 <input type="checkbox"/> No | | | | 10e. Street and Number
700 Wyndhurst Avenue | | 10f. Zip Code
21210 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner | | 16b. Kind of Business/Industry
Retail Hardware | | | | | |
| 17. Father's Name (First, Middle, Last)
Lewis Enoch Pratt | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Mann | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Susan C. Collins (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5515 Williams Road Hydes, Maryland 21082 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Gardens | | 20c. Date
8/29/00 | | 20d. Location - City or Town, State
Timonium, Maryland | | | |
| 21. Signature of Funeral Service Licensee
Steven T. Zoller | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Atherosclerotic Heart Disease
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
immediate
20 years
16 years | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Warren Israel, M.D. | | | | 29c. License number
D17803 | | 29d. Date signed (Month, Day, Year)
August 25, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Warren Israel, M.D. 6569 N. Charles Street #600 Towson, MD 21204 | | | | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27234

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Lynn Rubin

2. Date of Death

Aug 25, 2000

3. Time of Death

11:50 pm

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

212-92-4357

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 20, 1962

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11248-A SNOWFLAKE COURT

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TEACHER'S AIDE

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

BERNARD

LESTZ

18. Mother's Name (First, Middle, Maiden Surname)

SYLVIA

WEINER

19a. Informant's Name/Relationship (Type, Print)

STEVEN RUBIN - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11248-A SNOWFLAKE COURT - COLUMBIA, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OHEB SHALOM MEMORIAL PARK 8/28/00 REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jay Alan Lewis

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Encephalopathy
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

12 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fever

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bruce M. Conger MD Internist

29c. License number

D 37013

29d. Date signed (Month, Day, Year)

Aug. 26, 2000
Columbia, MD
21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce M. Conger MD #205, 11055 Little Patuxent Parkway

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Ben Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27235
Certificate of Death

Reg. No.

HUNTER
SHANK

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
HUNTER O. SHANK | | | | 2. Date of Death
Month Day Year
AUGUST 23, 2000 | | | | 3. Time of Death
8:05P.M. | | | | | |
| 4a. Facility Name (If not institution, give street and number)
328 McDOWELL AVE | | | | 4b. City, Town, or Location of Death
HAGERSTOWN | | | | 4c. County of Death
WASHINGTON | | | | | |
| 5. Social Security Number
220-16-4194 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
May 21, 1917 | | 9. Birthplace (State or Foreign Country)
MD | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
328 McDowell Avenue | | | | 10f. Zip Code
21740 | | | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
truck driver | | | | 16b. Kind of Business/Industry
asphalt | | | | | |
| 17. Father's Name (First, Middle, Last)
Russell J. Shank Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Pearl E. Snyder | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
O.C.M.E. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 Penn Street Baltimore, MD 21201 | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONTACT GUNSHOT WOUND TO HEAD
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/23/00 | | 28b. Time of Injury Found
1:55 PM | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT SHOTSELF | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
AT HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
328 McDOWELL AVE
HAGERSTOWN MD | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
J. A. L., M.D. | | | | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
AUGUST 24, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
Brenda S. Sparks | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27236

| | | | | | |
|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Brenda Simpson | | 2. Date of Death
Month August Day 25 Year 2000 | | 3. Time of Death
9:38 A.M. |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Hospital | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
219-42-5324 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
55 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
10-15-44 | | 9. Birthplace (State or Foreign Country)
md. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
md. | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
2431 E. HOFFMAN ST. | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (8-12) 10TH College (1-4 or 5+) N/A | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
UNEMPLOYED | | 16b. Kind of Business/Industry
N/A | | |
| | 17. Father's Name (First, Middle, Last)
NOAH MITCHELL | | 18. Mother's Name (First, Middle, Maiden Surname)
LUCILLE WOOTEN | | |
| | 19a. Informant's Name/Relationship (Type, Print)
REV CARROLL MITCHELL / Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3603 HANFORD RD. BALTO, MD. 21218 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
VOSHILL MEMORIAL GARDEN | | 20c. Location - City or Town, State
Baltimore, md. |
| | 21. Signature of Funeral Service Licensee
Funeral Committee | | 22. Name and Address of Facility
BETTS FUNERAL HOME
1129 N. CAROLINE ST. - BALTO, MD. 21213 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Postive hemorrhage
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c. Cerebrovascular Disease
Due to (or as a consequence of):
d. | | | | | Days
Years
Years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Mitzi Hemstreet MD, PhD | | 29c. License number
RES-000 | 29d. Date signed (Month, Day, Year)
August 25, 2000 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mitzi Hemstreet MD, PhD. Johns Hopkins Hospital 600 N Wolfe St. Baltimore, MD 21287 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27237

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LENORE CHINN SNYDER | | | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | 3. Time of Death
9:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
11630 Glen Arm Road, #G15 | | | | | | 4b. City, Town, or Location of Death
Glen Arm | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
215-03-5509 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar 10, 1916 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore County | | 10c. City, Town or Location
Glen Arm | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
11630 Glen Arm Road, #G-15 | | | | 10f. Zip Code
21057 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 yrs | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | 16b. Kind of Business/Industry
Church office | | | |
| 17. Father's Name (First, Middle, Last)
Leonard Chinn | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Eva Milburn | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara J. Barr (Daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9311 Hines Estates Drive, Baltimore, Maryland 21234 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | 20c. Date
8/30 | | 20d. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Representative
Martin D. Lawson | | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Myocardial Infarction
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Hypertension
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Mel Daly | | 29c. License number
D30433 | | 29d. Date signed (Month, Day, Year)
8/29/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mel Daly, M.D., 11630 Glen Arm Road, Glen Arm, Maryland 21157 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
Geneva B Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

James M. Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27238

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Phillip Solomon</i> | | 2. Date of Death
Month <i>AUGUST</i> Day <i>27</i> Year <i>2000</i> | | 3. Time of Death
<i>5:08 AM</i> |
| | 4a. Facility Name (If not institution, give street and number)
<i>Sinai Hospital of Baltimore</i> | | 4b. City, Town, or Location of Death
<i>Baltimore City</i> | | 4c. County of Death
<i>N/A</i> |
| Funeral
Director | 5. Social Security Number
<i>220-76-9071</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>90</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>April 21, 1960</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | 10b. County
<i>Baltimore</i> | 10c. City, Town or Location
<i>Randallstown</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
<i>3512 Kings Point Rd.</i> | | 10f. Zip Code
<i>21133</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11th Grade</i> College (1-4 or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Salesman</i> | | 16b. Kind of Business/Industry
<i>MCI</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>Earl Solomon</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Bertha Clanton</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Bertha Greene - mother</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3512 Kings Point Rd. Randallstown, MD 21133</i> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory, or other place)
<i>Lorraine Park Cem.</i> | | 20c. Location - City or Town, State
<i>9/1 Woodlawn Maryland</i> |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>Kevin Parker</i> | | 22. Name and Address of Facility
<i>Kevin A. Parker Funeral Home
3512 Frederick Ave. Baltimore, Maryland 21229</i> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. <i>pneumonia</i>
Due to (or as a consequence of):
b. <i>End stage Liver Disease</i>
Due to (or as a consequence of):
c. <i>AIDS</i>
Due to (or as a consequence of):
d. | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{ | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | |
| | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>Martha Blass, MD</i> | | 29c. License number
<i>RES 000</i> | | 29d. Date signed (Month, Day, Year)
<i>August 27, 2000</i> |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>2401 West Belvedere Avenue Baltimore, Maryland 21215</i> | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | 32. Registrar's Signature
<i>Benjamin B. Sparks</i> | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27239

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Traci Jean Starr

2. Date of Death

August 23 2000

3. Time of Death

9:00 P.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-94-6460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

22

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 25, 1977

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2281 Four Seasons Drive

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Greeter

16b. Kind of Business/Industry

Retail Clothing

17. Father's Name (First, Middle, Last)

Jim E. Starr

18. Mother's Name (First, Middle, Maiden Surname)

Judy A. Weaver

19a. Informant's Name/Relationship (Type, Print)

Jim E. Starr (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2281 Four Seasons Drive, Gambrills, MD 21054

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

08/26

2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Michael P. Kutta

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael P. Kutta

29c. License number

D43977

29d. Date signed (Month, Day, Year)

August 23 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela D. Brown, 39 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Jennifer G. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

STARR, TRACI J.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27240

| | | | | | | | | |
|---|---|---|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERTA S. SCROGGINS | | | | 2. Date of Death
Month Day Year
AUG 24 2000 | | 3. Time of Death
1:00 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
NOBLE HOUSE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
219-38-6922 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
FEB 19 1912 | 9. Birthplace (State or Foreign Country)
MD | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number
2522 RIGGS AVE. | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U S A | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DOMESTIC | | | 16b. Kind of Business/Industry
AT HOME | |
| 17. Father's Name (First, Middle, Last)
JAMES DALTON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ZORA CARTER | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOHANNA COTTMAN-GRANDDAUGH. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2522 RIGGS AVE. BALTO., MD 21216 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEMORIAL PARK | | 20c. Location - City or Town, State
8-29-00 BALTO., MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE. BALTO., MD 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <u>Atherosclerotic Cardiovascular disease</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Cancer Cervix; 170 Pneumothorax</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D17537 | | 29d. Date signed (Month, Day, Year)
8. 24. 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27241

AMENDED ITEM 10e PER FH G787 9/1/00 AH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Stuart Spangler

2. Date of Death
Month Day Year
August 26, 20003. Time of Death
2:40 P.M.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-01-1347

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 5, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number 8033 BANK STREET

~~833 East Bank Street~~

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Delivery Driver

16b. Kind of Business/Industry

Pharmaceutical Company

17. Father's Name (First, Middle, Last)

Charles Spangler

18. Mother's Name (First, Middle, Maiden Surname)

Edith Catherine Keenan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Doris Schmitz - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3429 Gaither Road; Baltimore, Maryland 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 08/30/2000 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00869

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road; Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CORONARY THROMBOSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H45931

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Deborah I. Pierce 7220 Park Heights Avenue Baltimore MD

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27242

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Ann Sargent

2. Date of Death

August

Day

23

2000

3. Time of Death

20:55

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-28-7129

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 3, 1933

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 Ridge Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

George Kouns

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Morris

19a. Informant's Name/Relationship (Type, Print)

Wilbur N. Sargent (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Ridge Avenue Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/25/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Kevin E. Ecker

22. Name and Address of Facility

McCutty-Polyniak Funeral Home, P.A.

237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Profound Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 6-8 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peritonitis

Due to (or as a consequence of):

~ 24-48 hr

c. Chronic Renal Failure

Due to (or as a consequence of):

many yrs ~ 2 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Peripheral Vascular dz, HTN, CAD

MI, Anemia, Mesenteric Ischemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was cause related to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Azadi, PGYII

29c. License number

P13598

29d. Date signed (Month, Day, Year)

8/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehdi Azadi, MD, St. Agnes Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Dennis B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME

GEORGIA A SARGENT

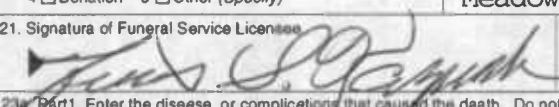
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

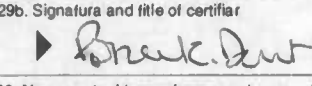
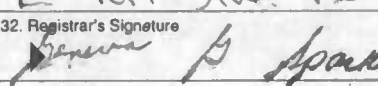
00 27243

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE RICHARD SMALLEY | | | | 2. Date of Death
Month AUGUST Day 28 Year 2000 | | 3. Time of Death
7:25 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1615 COVINGTON STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
302-16-0791 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 03 1926 | | 9. Birthplace (State or Foreign Country)
Peebles, Ohio |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1615 Covington Street | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineer | | 16b. Kind of Business/Industry
Chessie System | | |
| 17. Father's Name (First, Middle, Last)
William Smalley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Lytel | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Lacy Smalley (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1615 Covington Street, Baltimore, Md. 21230 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Pk. | | Date
9/01/00 | | 20c. Location - City or Town, State
Elkridge, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Ave. Baltimore, Md. 21230 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Arrhythmia
Due to (or as a consequence of):
b. Cardiomyopathy
Due to (or as a consequence of):
c. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
d. Congestive Heart Failure

Approximate Interval Between Onset and Death
mins.
5 yrs
15 yrs
10 yrs | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D39660 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Dert 901 E Fort Ave. Baltimore MD 21230 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permi. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27244

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

KATIE

V

TILLMAN

2. Date of Death

August 17 2000

Day Year

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital, 5601 Loch Raven Blvd

4b. City, Town, or Location of Death

Baltimore, Baltimore City

4c. County of Death

Baltimore City

5. Social Security Number

213-30-5919

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

8. Date of Birth (Month, Day, Year)

06/16/1922

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State
MD10b. County
n/a10c. City, Town or Location
Baltimore10d. Inside City Limits
☒ Yes 2 ☐ No

10e. Street and Number

1137 N. Bentalou Street

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Child Care

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Samuel Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Pearlie Sturdivant

19a. Informant's Name/Relationship (Type, Print)

Johnsie Spencer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2545 St. Georges St., Baltimore, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/25/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Willie E. Howell, per DVR

22. Name and Address of Facility

Howell Funeral Home, 4600 Liberty Hgts Ave., Baltimore, MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

One week

b. pneumonia

Due to (or as a consequence of):

two weeks

c. Urinary Tract Infection

Due to (or as a consequence of):

two weeks

d. Acute Renal Failure

One week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Origin Gao, MD

29c. License number

P14417

29d. Date signed (Month, Day, Year)

August 28, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Good Samaritan Hospital, 5601 Loch Raven Blvd, Baltimore, MD 21239

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1945

1946

1947

1948

1949

1950

1951

1952

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#15 PER F.H. G787 9-8-2000 JAB

Reg. No.

00 27245

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Clare Temple</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>27</i> Year <i>2000</i> | | 3. Time of Death
<i>1625</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Anne Arundel Medical Center</i> | | | | 4b. City, Town, or Location of Death
<i>Annapolis</i> | | 4c. County of Death
<i>Anne Arundel</i> | |
| Funeral
Director | 5. Social Security Number
<i>413-40-0175</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>83</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Sept. 17, 1916</i> | 9. Birthplace (State or Foreign Country)
<i>Washington, DC</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Gambrills</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
<i>2342 Columbine Court</i> | | | | 10f. Zip Code
<i>21054</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>Harold Love</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Clara McIntosh</i> | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Lynne M. Sotak (Daughter)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2342 Columbine Court, Gambrills, MD 21054</i> | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Gate of Heaven Cemetery</i> | | Date
<i>08/30 2000</i> | | 20c. Location - City or Town, State
<i>Silver Spring, MD</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Michael P. Lutta</i> | | | | 22. Name and Address of Facility
<i>Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Cardiomyopathy</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Possible Sepsis</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature] MD</i> | | 29c. License number
<i>D19838</i> | | 29d. Date signed (Month, Day, Year)
<i>August 27, 2000</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Stuart E. Selonick
Annapolis Medical Specialist 900 Bortgoff Rd. Suite 300, Annapolis MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27246

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|--|---|--|---------------------------------|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARIE H TARBUTTON | | | | 2. Date of Death
Month August Day 27 Year 2000 | | | | 3. Time of Death
3:35 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Nursing Center
1601 East Belvedere | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-68-2063 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
4/10/08 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PERRY HALL | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
9720 HICKORYHURST DRIVE | | | | 10f. Zip Code
21236 | | | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | |
| 17. Father's Name (First, Middle, Last)
JOHN J. CONNELLY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HELEN M. CONNOLLY | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
SHIRLEY T. BONNER DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9720 HICKORYHURST DR. BALTIMORE, MD 21236 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. GAR. 8/30/00 | | | | 20c. Location - City or Town, State
COCKEYSVILLE, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A.
8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Dehydration
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
More Than | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Poor Intake of food and fluids
Due to (or as a consequence of): | | | | | | One week | | |
| | | c. _____
Due to (or as a consequence of): | | | | | | | | |
| | | d. _____
Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Dr. Suresh K. Tripathi | | | | 29c. License number
D 30661 | | |
| | | | | 29d. Date signed (Month, Day, Year)
August 27th 2000 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh K. Tripathi
1601 East Belvedere, Baltimore, Md - 21239 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27247

| | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LAURA C. VEREEN | | | | 2. Date of Death
Month AUGUST Day 28 Year 2000 | | 3. Time of Death
4:20 pm | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
905 LONGVIEW AVE. | | | | 4b. City, Town, or Location of Death
PASADENA | | 4c. County of Death
ANNE ARUNDEL CO. | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-32-2713 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 14 1937 | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State
Md. | | 10b. County
Anne Arundel Co. | | 10c. City, Town or Location
Pasadena | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
905 Longview Ave. | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
USA | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home Owner | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Cooke | | | | 18. Mother's Name (First, Middle, Maiden Summa)
LaVern Brookman | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert D. Vereen Sr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
905 Longview Ave Pasadena, Md. 21122 | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Pk. | | Date
9/01/2000 | | 20c. Location - City or Town, State
Glen Burnie, Md. | | | | | | | |
| 21. Signature of Funeral Service Licensed
 | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Md. 21122 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. Metastatic Lung Cancer
Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death
3 months</td> </tr> <tr> <td>b. _____
Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____
Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____
Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. Metastatic Lung Cancer
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
3 months | b. _____
Due to (or as a consequence of): | c. _____
Due to (or as a consequence of): | d. _____
Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. Metastatic Lung Cancer
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
3 months | | | | | | | | | | | | |
| | b. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| | c. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| | d. _____
Due to (or as a consequence of): | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
DS3462 | | 29d. Date signed (Month, Day, Year)
8/29/00 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jude M. Barnes MD 7845 Oakwood Road Glen Burnie, MD 21061 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
 | | | | | | | | | | | |

with great interest

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | | |
|--|--|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWARD GABRIEL VENDETTI | | | | 2. Date of Death
Month Day Year
AUGUST 26 2000 | | | | 3. Time of Death
16:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SHOCK TRAUMA | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
BALTIMORE CITY | |
| Funeral
Director | 5. Social Security Number
218-72-9455 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
43 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 14, 1957 | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore County | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
3503 Buckboard Rd. | | | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Boiler Maker | | | 16b. Kind of Business/Industry Incorporated
Industrial Maintenance Incorporated | | | |
| 17. Father's Name (First, Middle, Last)
Stephen Michael Vendetti, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Janet Marion Gabrielson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Janet M. Gabrielson | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
748 Camberley Circle Apt. C4 Towson, Md. 21204 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | Date
8-30-2000 | | 20c. Location - City or Town, State
Baltimore, Md. | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | 22. Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Md. 21236 | | | | | |
| 23a. Pertinent illness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Multiple Injuries
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year)
8-25-00 | | 28b. Time of Injury
6:45 P M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
OPERATOR OF A MOTORCYCLE STRUCK A FIXED OBJECT
RAMP FROM RT. 40 TO WESTBOUND I-695
ROSEDALE MD. | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>[Signature]</i> | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 27, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutem 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27249

| | | | | | |
|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEONARD WHITE | | 2. Date of Death
Month AUGUST Day 24 Year 2000 | | 3. Time of Death
8:15AM |
| | 4a. Facility Name (If not institution, give street and number)
MERCY HOSPITAL / STELLA MARIS HOSPICE | | 4b. City, Town, or Location of Death
BAITIMORE | | 4c. County of Death
— |
| Funeral
Director | 5. Social Security Number
083-60-6456 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | 8. Date of Birth (Month, Day, Year)
AUG. 19, 1920 |
| | 9. Birthplace (State or Foreign Country)
JAMAICA | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
BALTIMORE | 10c. City, Town or Location
ROSEDALE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
5024 SPRINGHOUSE CIR | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CHIEF OFFICE ASSISTANT | | 16b. Kind of Business/Industry
MINISTRY OF NATIONAL SECURITY & JUSTICE; KINGSTON, JAMAICA | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
CHARLES WHITE | | 18. Mother's Name (First, Middle, Maiden Surname)
SUSETTE MORGAN | | |
| | 19a. Informant's Name/Relationship (Type, Print)
TIMOTHY MCCLAIN, SON-IN-LAW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5024 SPRINGHOUSE CIR. ROSEDALE, MD. 21237 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH CEM. | | 20c. Location - City or Town, State
ROSEDALE, MD. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
EVAN'S FUNERAL CHAPEL
8800 HARFORD RD. PARKVILLE, MD 21234 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Cancer of liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D40854 | | 29d. Date signed (Month, Day, Year)
8/24/2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. A. Rieberg 301 St Paul Pl Baltimore 21202 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27250

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Lolita M. Waldner</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>26</i> Year <i>2000</i> | | 3. Time of Death
<i>8:30 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Franklin Square Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Rosedale</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>215-16-1697</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>76</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
<i>Dec. 29 1923</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
<i>Md</i> | 10b. County
<i>Baltimore</i> | 10c. City, Town or Location
<i>Perry Hall</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>7720 Bennerton Dr.</i> | | | | 10f. Zip Code
<i>21236</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>homemaker</i> | | 16b. Kind of Business/Industry
<i>home</i> | | | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>Edgar Larsh</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Elizabeth Chisholm</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Philip G. Waldner spouse</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>7720 Bennerton Dr. Baltimore, Md 21236</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>GARRISON FOREST VA Cem. 2000</i> | | 20c. Location - City or Town, State
<i>Garrison, Maryland</i> | | 20d. Date
<i>Aug 29</i> | |
| | 21. Signature of Funeral Service Licensee
<i>Krista S. Udell</i> | | 22. Name and Address of Facility
<i>Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234</i> | | | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
<i>a. Multiple Myeloma</i>
Due to (or as a consequence of): | | | | | | | | <i>3 months</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner | | 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
<i>H.D.</i> | | 29c. License number
<i>D41590</i> | | 29d. Date signed (Month, Day, Year)
<i>August 26th., 2000</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Myo Man (M.D.) 6880 Hospital Dr. #206, Baltimore, MD 21237</i> | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
<i>AUG 29 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

ORIGINAL

1. The first part of the report
describes the general situation
of the country and the
state of the economy.
It also mentions the
main problems which
the government is facing.
The second part of the
report deals with the
social and cultural
aspects of the country.
It discusses the
education system, the
health services, and the
cultural heritage.
The third part of the
report is devoted to the
environmental issues.
It talks about the
pollution, the deforestation,
and the protection of
the natural resources.
The fourth part of the
report is a conclusion
and a summary of the
main findings.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27251

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marie Johanna Will | | | 2. Date of Death
Month Day Year
August 25 2000 | | 3. Time of Death
12:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care - Towson | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
138-54-6964 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
99 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 22 1901 | 9. Birthplace (State or Foreign Country)
New Jersey | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
409 Cedarcroft Road | | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
1 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Gustav Kleindienst | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Johanna Wostbrock | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Raymond Will (Son) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 Cedarcroft Road Baltimore, Maryland 21212 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Immanuel Lutheran Ch. Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
8/29/00 | |
| 21. Signature of Funeral Service Licensee
Steven T. Bittle | | | 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, MD 21212 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. End stage Dementia
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
MA | | | 29c. License number
D44796 | | | 29d. Date signed (Month, Day, Year)
8-25-00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAMMED AHMED 9512 HARGROVE RD, BALTIMORE MD 21234 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
B. Jones | | | | | |

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27252

| | | | | | |
|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LETISHA MONETTE WILLIAMS | | 2. Date of Death
Month AUGUST Day 26 , Year 2000 | | 3. Time of Death
9:20 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
41 CHEVIOT COURT | | 4b. City, Town, or Location of Death
WOODLAWN | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
213-86-1972 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
30 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
02-16-70 | | 9. Birthplace (State or Foreign Country)
BALTIMORE, MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE, MARYLAND | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
41 CHEVIOTT COURT | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
correctional officer | | 16b. Kind of Business/Industry
A.A COUNTY DETENTION | |
| 17. Father's Name (First, Middle, Last)
SONNY CHADLER | | 18. Mother's Name (First, Middle, Maiden Surname)
BARBARA SYDNOR | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MICHAEL WILLIAMS, HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
411 SECLUDED POST CIRCLE, PASADENA, MD 21226 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT ZION UM, CEMET. | | 20c. Location - City or Town, State
9-1-00 PASADENA, MD | |
| 21. Signature of Funeral Service Licensee
<i>Rose M. Smith</i> | | 22. Name and Address of Facility
HOWELL FUNERAL HOME
4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <i>Contact Gunshot Wound of Front of Chest</i>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8-26-00 | | 28b. Time of Injury
10:55 PM | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
self-inflicted gunshot | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
41 Cheviot St Baltimore Co, Md | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>Dennis J Chute</i> | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 27, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
<i>Dennis J Chute</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2

LORRETTA WALTERS
amend item 1,23,27,per me G787 9/29/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27253

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORRETTA VERBINA WALTERS | | | | 2. Date of Death
Month Day Year
AUGUST 26 2000 | | | | 3. Time of Death
8:52 AM | | |
| | LORRETTA VERBINA WALTERS BOOZE | | | | | | | | | | |
| Funeral
Director | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | | | 4c. County of Death
BALTIMORE | | |
| | 5. Social Security Number
215-65-3725 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
7-10-55 | | 9. Birthplace (State or Foreign Country)
BALTO. MD | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTO | | 10c. City, Town or Location
RANDALLSTOWN | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
8507 GREENS LANE | | | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER | | | | 16b. Kind of Business/Industry
BOARD OF EDUCATION | | | |
| 17. Father's Name (First, Middle, Last)
SYLVESTER JOHNSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMMA WALTERS | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
GORDON BOOZE, HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8507 GREENS LANE, RANDALLSTOWN, MD 21244 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY | | 20c. Location - City or Town, State
9-1-00 ARBUTUS, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HOWELL FUNERAL HOME
4600 LIBERTY HGHTS AVE, BALTO. MD 21207 | | | | | | | |
| 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASTHMA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
AUGUST 27, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27254

| | | | | | | | | | | |
|--|---|------------------------------------|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORE EMILIE WALTER | | | | | | 2. Date of Death
Month Day Year
AUGUST 27 2000 | | 3. Time of Death
2:40 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
GENESIS ELDER CARE HAMMONDS LANE | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
ANNE ARUNDEL COUNTY | |
| Funeral
Director | 5. Social Security Number
212-22-5561 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 30, 1926 | | 9. Birthplace (State or Foreign Country)
Germany | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Hanover | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
7553 Teague Road | | | | 10f. Zip Code
21076 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Real Estate Broker | | | 16b. Kind of Business/Industry
Self Employed | | | |
| 17. Father's Name (First, Middle, Last)
Frederick Bauer | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Auchter | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Loran E. Walter (Son) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4434 E. Joppa Rd., #106, Balto., Md. 21236 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Pk. 8/30/00 | | | 20c. Location - City or Town, State
Glen Burnie, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Kevin E. Ecker | | | | | | 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Ave., Balto., Md. 21225-1856 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
2 YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
OLD CEREBROVASCULAR ACCIDENT
SEIZURE DISORDER | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
[Signature] | | | 29c. License number
21776 | | 29d. Date signed (Month, Day, Year)
AUGUST 28 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURAJA WONDRA MD 3001 S. HANOVER ST BALTIMORE 21225 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27255

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---------------------------------------|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillian Mary Whipp | | | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
10:59 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-10-7977 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth
Month Day Year
AUG 4, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
7617 Daniels Avenue | | | | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
Clarence Bennett | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Pearl George | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John R. Whipp/husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7617 Daniels Avenue Baltimore, MD 21234 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | Date
8/29/00 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
Thomas Gregor | | | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
D45475 | | 29d. Date signed (Month, Day, Year)
8/28/2000 | | | | |
| 30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)
MOHAMMAD RAHNAMA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | 32. Registrar's Signature | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27256

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|---|---|--|---|---|---|--|---|--|--|---------------------------------------|---------------------------------|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY CATHERINE WOLF | | | | | 2. Date of Death
Month Day Year
AUGUST 22, 2000 | | 3. Time of Death
10:20 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE GERIATRIC CENTER | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
220-14-4739 | | 6. Sex
1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
09-25-1924 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TOWSON | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
1314 HIGHLAND DRIVE | | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
XX Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes XX No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes XX No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS
College (1-4or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MANAGER | | | 16b. Kind of Business/Industry
RAIL ROAD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
ERNEST WOLF | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ADA (UNK.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ADELE D. STRUMMER (POA) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1314 HIGHLAND DR., TOWSON, MARYLAND, 21239 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial XX <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GREEN MOUNT CREMATORY | | | Date
8-24 | | 20c. Location - City or Town, State
BALTIMORE, MD., 21202 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
HENRY W. JENKINS AND SONS COMPANY
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width:70%; vertical-align: top;"> <table border="0" style="width:100%;"> <tr> <td style="width:60%;"> a. METASTIC PANCREATIC CANCER
Due to (or as a consequence of): </td> <td style="width:40%; vertical-align: top;"> Approximate Interval Between Onset and Death
WEEKS </td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> b.
Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> c.
Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> d.
Due to (or as a consequence of): </td> <td></td> </tr> </table> </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | <table border="0" style="width:100%;"> <tr> <td style="width:60%;"> a. METASTIC PANCREATIC CANCER
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Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> c.
Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> d.
Due to (or as a consequence of): </td> <td></td> </tr> </table> | a. METASTIC PANCREATIC CANCER
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
WEEKS | b.
Due to (or as a consequence of): | | c.
Due to (or as a consequence of): | | d.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | |
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Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> c.
Due to (or as a consequence of): </td> <td></td> </tr> <tr> <td style="border-left: 2px solid black; padding-left: 10px;"> d.
Due to (or as a consequence of): </td> <td></td> </tr> </table> | a. METASTIC PANCREATIC CANCER
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
WEEKS | b.
Due to (or as a consequence of): | | c.
Due to (or as a consequence of): | | d.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. METASTIC PANCREATIC CANCER
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
WEEKS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d.
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:70%;"> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. </td> <td style="width:30%;"> 23b. Did tobacco use contribute to the cause of death?
 1 <input type="checkbox"/> Yes XX No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown </td> </tr> <tr> <td> 24a. Was an autopsy performed?
 1 <input type="checkbox"/> Yes XX No </td> <td> 24b. Were autopsy findings available prior to completion of cause of death?
 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> </tr> </table> | | | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes XX No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes XX No | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes XX No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes XX No | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%;"> 25. Was case referred to medical examiner?
 1 <input type="checkbox"/> Yes XX No </td> <td colspan="7"> 26. Place of Death (Check only one)
 Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: XX Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) </td> </tr> <tr> <td> 27. Manner of Death
 XX Natural 5 <input type="checkbox"/> Pending Investigation
 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
 3 <input type="checkbox"/> Suicide
 4 <input type="checkbox"/> Homicide </td> <td> 28a. Date of Injury (Month, Day Year) </td> <td> 28b. Time of Injury
 M </td> <td> 28c. Injury at Work?
 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No </td> <td colspan="6"> 28d. Describe how injury occurred </td> </tr> <tr> <td colspan="4"> 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) </td> <td colspan="6"> 28f. Location (Street and Number or Rural Route Number, City or Town, State) </td> </tr> </table> | | | | | | | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes XX No | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: XX Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | 27. Manner of Death
XX Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide
4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes XX No | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: XX Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
XX Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide
4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D33943 | | 29d. Date signed (Month, Day, Year)
AUGUST 23, 2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN M. LEVY, M.D., 2434 W. BELVEDERE AVENUE, BALTIMORE, MD., 21215 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27257

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KURT

G.

WEINBERG

2. Date of Death

Month Day Year
AUGUST 27, 2000

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

GENESIS CARE - LOCH RAVEN

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

087-22-6522

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEP. 28, 1925

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

n/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3018 FALLSTAFF MANOR COURT #F

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No NAVYIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

HOME FURNISHINGS

17. Father's Name (First, Middle, Last)

ISAAC

WEINBERG

18. Mother's Name (First, Middle, Maiden Surname)

SELMA

HERMAN

19a. Informant's Name/Relationship (Type, Print)

INGE GUTTMAN / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14801 PENNFIELD CIRCLE #410 - SILVER SPRING, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHEVRA AHAVAS CHESED

Date

8/27/00

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Ventricular Tachycardia

Due to (or as a consequence of):

Ischemic Cardiac Myopathy

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Attending Physician. D53642

Aug 27 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X/AD 2404 3007 E Northern Parkway Baltimore 21214

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Bennett J. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27258

amend item 11 per fh G786 8/29/00 yf

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)
JACK WEINTRAUB | | 2. Date of Death
Month Day Year
AUGUST 25, 2000 | | 3. Time of Death
7:28 PM | |
| 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE |
| 5. Social Security Number
212-03-7396 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAY 12, 1913 |
| 9. Birthplace (State or Foreign Country)
MD | | Usual Residence of Decedent | | | |
| 10a. State
MD | 10b. County
BALTIMORE | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
4501 SCOTTS LEVEL COURT | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates:
WWII NAVY | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (14 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALESMAN | | 16b. Kind of Business/Industry
INSURANCE | | | |
| 17. Father's Name (First, Middle, Last)
LOUIS WEINTRAUB | | | 18. Mother's Name (First, Middle, Maiden Surname)
PEARL ELLISON | | |
| 19a. Informant's Name/Relationship (Type, Print)
DOTSY WEINTRAUB / DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8018 VALLEY MANOR ROAD #1A - OWINGS MILLS, MD 21117 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CHIZUK AMUNO | | 20c. Location - City or Town, State
8/28/00 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee
Scott M. Cottle | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY FAILURE
Due to (or as a consequence of):
b. PNEUMONIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death
4 HOURS
2 DAYS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Scott M. Cottle MD | | 29c. License number
042587 | | 29d. Date signed (Month, Day, Year)
AUGUST 25, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT FINE, MD 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
B. Sparks | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27259

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS LUCILLE YORKMAN

2. Date of Death

Month Day Year
AUGUST 20, 2000

3. Time of Death

10:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5220 York Road Apt 3N

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-30-6505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 18, 1936

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5220 York Road Apr 3N

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Clarence B. Vinson

18. Mother's Name (First, Middle, Maiden Surname)

Christine V. Stallings

19a. Informant's Name/Relationship (Type, Print)

Charles Yorkman/former spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

532 Richwood Avenue Baltimore, MD 21212

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

5YR

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

DIABETES MELLITUS - TYPE II

10YR

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD RECURRENT RESPIRATORY FAILURE

HYPERTENSION, HYPERLIDEMIA

MULTIPLE MYELOMA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

Investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Nesbitt III MD

29c. License number

D0014623

29d. Date signed (Month, Day, Year)

8/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN A. NESBITT III MD S. 351 200 E. 33RD ST, BALT., MD 21218

State
Registrar

31. Date filed (Month, Day, Year)

AUG 29 2000

32. Registrar's Signature

Bryana Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is mirrored and difficult to decipher.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27260

| | | | | | |
|---|--|---|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MIKHAIL ZHURAVEL | | 2. Date of Death
Month Day Year
AUGUST 27, 2000 | | 3. Time of Death
5:10 AM |
| | 4a. Facility Name (If not institution, give street and number)
10007 WOODKEY LANE #8 | | 4b. City, Town, or Location of Death
OWINGS MILLS | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
217-33-6611 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
SEP. 22, 1928 | | 9. Birthplace (State or Foreign Country)
RUSSIA | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
OWINGS MILLS | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
10007 WOODKEY LANE #8 | | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MECHANIC | | 16b. Kind of Business/Industry
ENGINEERING | |
| 17. Father's Name (First, Middle, Last)
CHAIM ZHURAVEL | | 18. Mother's Name (First, Middle, Maiden Surname)
RIVA ZARETSKIY | | | |
| 19a. Informant's Name/Relationship (Type, Print)
RIVA ZHURAVEL / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10007 WOODKEY LANE #8 - OWINGS MILLS, MD 21117 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BALTIMORE HEBREW CEMETERY | | 20c. Location - City or Town, State
8/28/00 REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. gastric adenocarcinoma
Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death
2 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
025001 | | 29d. Date signed (Month, Day, Year)
08-27-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAY LIPPMAN MD 10085 RED RUN BLVD OWINGS MILLS MD 21117 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 29 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27261

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN HOBART ATKINS

2. Date of Death

Month Day Year
AUGUST 10, 2000

3. Time of Death

12:17 A.M.

4a. Facility Name (If not institution, give street and number)

ST CATHERINE'S NURSING CENTER

4b. City, Town, or Location of Death

EMMITSBURG

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

216-44-3186

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 28, 1911

9. Birthplace (State or Foreign Country)

GLENWILLOW, OH

Usual Residence of Decedent

10a. State

OHIO

10b. County

WAYNE

10c. City, Town or Location

BURBANK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13955 BURBANK RD

10f. Zip Code

44214

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUREAU OF PUBLIC DEBT.

16b. Kind of Business/Industry

TREASURY DEPT.

17. Father's Name (First, Middle, Last)

WILLIAM J. ATKINS

18. Mother's Name (First, Middle, Maiden Surname)

CHLOE PORTS

19a. Informant's Name/Relationship (Type, Print)

LINDA POSTELLE/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. BOX 1290, EMMITSBURG, MD. 21727

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SMITHSBURG CREMATORIUM 8/11/2000

20c. Location - City or Town, State

SMITHSBURG, MD.

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERAL HOME

210 W. MAIN ST. BOX 427, EMMITSBURG, MD. 21727

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia (left lower lobe).

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's - advanced.

8 yrs

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration.

Atrial fibrillation

Cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bonita O Krempel-Fortier DO

29c. License number

H44037

29d. Date signed (Month, Day, Year)

11 AUGUST 2000

30. Name and address of person who completed cause of death (Page 2a) (Type, Print)

Bonita O Krempel-Fortier DO

52 WATER STREET THURMONT, MD 21727

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27262

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAURICE LEONARD ARNOLD | | | | 2. Date of Death
Month Day Year
AUGUST 11 2000 | | 3. Time of Death
8:05 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
710-09-7976 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 30 1909 | |
| | 9. Birthplace (State or Foreign Country)
Knoxville, MD | | 10a. State
MD | | 10b. County
Frederick | | 10c. City, Town or Location
Knoxville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
3501 Petersville Road | | 10f. Zip Code
21758 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carman | | 16b. Kind of Business/Industry
B&O Railroad | | | |
| | 17. Father's Name (First, Middle, Last)
Andrew David Arnold | | 18. Mother's Name (First, Middle, Maiden Surname)
Amanda Catherine Young | | | | | |
| To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print)
Catharine B. Arnold, Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3501 Petersville Road, Knoxville, MD 21758 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Park Heights Cemetery | | 20c. Location - City or Town, State
Brunswick, MD | | 20d. Date
8/14/2000 | |
| To Be Completed by Funeral Director | 21. Signature of Funeral Service Licensee
Barbara A. Williams, Owner | | 22. Name and Address of Facility
John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Renal failure
Due to (or as a consequence of):
Metastatic Prostate Cancer
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pathologic fracture of Left Humerus, anorexia,
Recurrent esophageal stricture, coronary artery disease | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D47169 | | 29d. Date signed (Month, Day, Year)
8/11/2000 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ho, Chan-hing 610 9th Avenue, Brunswick, MD 21716 | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
[Signature] | | | |
| | 33. State Registrar | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27263

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Margie Lee Adkins | | | | 2. Date of Death
Month Day Year
August 9, 2000 | | | | 3. Time of Death
9:10 pm | |
| 4a. Facility Name (If not institution, give street and number)
600 E. Elizabeth Street | | | | 4b. City, Town, or Location of Death
Delmar | | | | 4c. County of Death
Wicomico | |
| 5. Social Security Number
214-16-4519 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 5, 1904 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Wicomico | | 10c. City, Town or Location
Delmar | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
600 E. Elizabeth Street | | | | 10f. Zip Code
21875 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 Collage (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Trimmer | | | 16b. Kind of Business/Industry
Garment Company | | |
| 17. Father's Name (First, Middle, Last)
George Wilkins | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Griffin Wilkins | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Clyde Adkins/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6175 Ox Bridge Drive Salisbury, MD 21801 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Powellville Cemetery | | Date
8-13-2000 | | 20c. Location - City or Town, State
Powellville, MD | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street Delmar, DE 19940 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CCHF
HTN
ASND
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
GIBD | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
C-10005184 | | | 29d. Date signed (Month, Day, Year)
8/10/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alex Jerome 360 N. Dual Hwy. Laurel, DE 19956 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
8/10/00 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27264

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Aglae Cuppa Brown

2. Date of Death

Month Day Year
August 14th 2000

3. Time of Death

2:44 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

258-01-7953

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 23, 1898

9. Birthplace (State or Foreign Country)

Smyrna, Turkey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

730 MD Route 3 South

10f. Zip Code

21054

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

D. George Cuppa

18. Mother's Name (First, Middle, Maiden Surname)

Katia Cuppa

19a. Informant's Name/Relationship (Type, Print)

Julie Fife / Stepdaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2797 Berth Terrace Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

Arlington National Cemetery

Date

8/23/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory failure.

Due to (or as a consequence of):

1 day.

c. Old age.

Due to (or as a consequence of):

102.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

GURMEET S. SAWHNEY MD

29c. License number

D44973

29d. Date signed (Month, Day, Year)

August 14th 2000.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Hospital Dr. Glen Burnie, MD 21061

Gurmeet Sawhney MD

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. Sparks

State
RegistrarAglae C. Brown
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

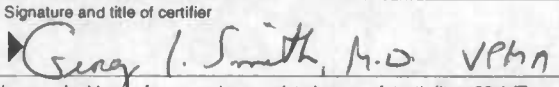
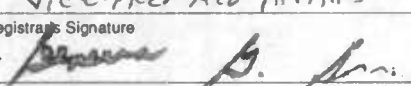
00 27265

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FORREST LEROY BENNETT | | | | 2. Date of Death
Month Day Year
AUG. 3, 2000 | | 3. Time of Death
5:04 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
373-05-4179 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 4, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Iowa | | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
4113 Baker Valley Road | | 10f. Zip Code
21704 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanical Engineer | | 16b. Kind of Business/Industry
Oil Company | | | | |
| 17. Father's Name (First, Middle, Last)
Jessie Bennett | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Harriet Hurst | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jane L. Page / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4113 Baker Valley Road, Frederick, Maryland 21704 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery | | 20c. Location - City or Town, State
Frederick, Maryland | | 20d. Date
August 14, 2000 | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike, Frederick, Maryland 21702 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RUPTURED AORTIC ANEURYSM
Due to (or as a consequence of):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA OF THE PROSTATE
HYPERTENSION | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier

George I. Smith, M.D. VPHN | | 29c. License number
D 10587 | | 29d. Date signed (Month, Day, Year)
8/8/2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE I. SMITH, M.D. VICE-PRES. MED. AFFAIRS
FREDERICK MEMORIAL HOSP
FREDERICK, MARYLAND 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27266

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|--|---|--|--------------------------|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PAMELA J. BRANDT | | | | 2. Date of Death
Month Day Year
August 14 2000 | | | | 3. Time of Death
1056 | | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | | | 4c. County of Death
Talbot | | |
| Funeral
Director | 5. Social Security Number
184-42-3144 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
34 Yrs. | | 8. Date of Birth (Month, Day, Year)
04-12-1966 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Delaware | | 10b. County
Sussex | | 10c. City, Town or Location
Seaford | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
23687 Old Meadow RD | | | | 10f. Zip Code
19973 | | | | 10g. Citizen of What Country?
US | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Home Owner | | | |
| 17. Father's Name (First, Middle, Last)
Donald Kittle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Hyde | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Christian Brandt - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23687 Old Meadow Rd, Seaford, DE 19973 | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Capitol Crematory | | Date
8/15/2000 | | 20c. Location - City or Town, State
Dover, DE | | | |
| 21. Signature of Funeral Service Licentiate
John A. Cranston | | | | 22. Name and Address of Facility
Cranston Funeral Home
P O Box 967, Seaford, DE 19973 | | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute myelogenous leukemia
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { | | | | | | | | | | Approximate Interval Between Onset and Death
3 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic graft vs. host disease | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
David H. Smith MD | | | | 29c. License number
D39887 | | 29d. Date signed (Month, Day, Year)
8/14/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David H. Smith MD, 29466 Pintail Dr, Easton, MD 21601 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
S. Sparks | | | | | | | |

ORIGINAL

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edna Irene Brotemarkle | | 2. Date of Death
Month Day Year
AUGUST 22 2000 | | 3. Time of Death
7:30 P |
| | 4a. Facility Name (If not institution, give street and number)
12916 N. CRESAP ST. APT#11 | | 4b. City, Town, or Location of Death
CRESAPTOWN | | 4c. County of Death
ALLEGANY |
| Funeral
Director | 5. Social Security Number
214-46-3518 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
55 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Aug 8, 1945 | | 9. Birthplace (State or Foreign Country)
MD | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cresaptown | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
12916 N. Cresap Street Apt. 11 | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1964-68 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired Word Processor | | 16b. Kind of Business/Industry
Alleg Co Health | |
| 17. Father's Name (First, Middle, Last)
James Leslie Brotemarkle | | 18. Mother's Name (First, Middle, Maiden Surname)
Rebecca I (Long) | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James L. Brotemarkle brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
434 Chestnut Street; Cumberland MD 21502 | | | |
| 20a. Manner of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home | | 20c. Location - City or Town, State
8/23/ Cresaptown, MD | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Cumberland, MD 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
OXYCODONE INTOXICATION | | | | | |
| 23b. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23c. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23d. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23e. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23f. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23g. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23h. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23i. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23j. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23k. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23l. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23m. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23n. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23o. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23p. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23q. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23r. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23s. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23t. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23u. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23v. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23w. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23x. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23y. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23z. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23aa. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ab. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ac. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ad. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ae. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23af. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ag. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ah. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ai. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23aj. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ak. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23al. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23am. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23an. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ao. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ap. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23aq. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ar. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23as. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23at. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23au. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23av. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23aw. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ax. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ay. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23az. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ba. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bb. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bc. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bd. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23be. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bf. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bg. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bh. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bi. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bj. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bk. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bl. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bm. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bn. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bo. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bp. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bq. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23br. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bs. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bt. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bu. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bv. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bw. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bx. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23by. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23bz. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ca. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cb. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cc. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cd. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ce. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cf. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cg. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ch. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ci. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cj. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ck. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cl. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cm. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cn. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23co. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cp. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cq. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cr. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cs. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23ct. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cu. Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____ | | | | | |
| 23cv. Due to (or as a consequence of):
a. _____
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| 23cw. Due to (or as a consequence of):
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| 23cx. Due to (or as a consequence of):
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| 23cy. Due to (or as a consequence of):
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| 23cz. Due to (or as a consequence of):
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| 23da. Due to (or as a consequence of):
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| 23db. Due to (or as a consequence of):
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| 23dc. Due to (or as a consequence of):
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| 23ds. Due to (or as a consequence of):
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| 23ea. Due to (or as a consequence of):
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27268

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES REGIS BRENNEN

2. Date of Death

Month Day Year
Aug. 15, 2000

3. Time of Death

11:48PM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

197-20-9324

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
April 13, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Allegheny

10c. City, Town or Location

North Versailles

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 Mahoney Drive

10f. Zip Code

15137

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: - 1946
- 1949

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Structural steelworker

16b. Kind of Business/Industry

Steel Manufacturer

17. Father's Name (First, Middle, Last)

John Brennen

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Cox

19a. Informant's Name/Relationship (Type, Print)

Margaret Gunderman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4134 Lancaster Circle, Waldorf, MD 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Braddock Catholic Cem. 8/19/00 Braddock, PA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Echols M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.
P.O. BOX 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician:2 ☒ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Yahia M. Tagouri, M.D.

29c. License number

D-50883

29d. Date signed (Month, Day, Year)

8-16-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yahia M. Tagouri, M.D. 25500 Pt. Lookout Rd. Leonardtown, MD 20560

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27269

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

| | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
HELEN A. BERGGREN | | | | 2. Date of Death
Month Day Year
AUGUST 17 2000 | | | | 3. Time of Death
8:30 AM | | | |
| 4a. Facility Name (If not institution, give street and number)
CHARLES COUNTY NURSING AND REHAB CENTER | | | | 4b. City, Town, or Location of Death
LA PLATA | | | | 4c. County of Death
CHARLES | | | |
| 5. Social Security Number
082-03-9863 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
DEC 26 1912 | |
| 9. Birthplace (State or Foreign Country)
North Dakota | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
La Plata | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
10200 La Plata Road | | | | 10f. Zip Code
20646 | | | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Counselor | | | | 16b. Kind of Business/Industry
Education | | | |
| 17. Father's Name (First, Middle, Last)
Henrik Larson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Amelie Froyland Larson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Carol B. Flowers (Daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7195 Henson Landing Road Welcome, Maryland 20693 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | | Date
8-18-00 | | 20c. Location - City or Town, State
Alexandria, VA | | | |
| 21. Signature of Funeral Service Licensee
 | | M00173 | | 22. Name and Address of Facility
Eberwein Funeral Services
4433 White Pls. La. White Pls., MD 20695 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEVERE ANEMIA
MYELOPROLIFERATIVE DISORDER
DEMENTIA | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D-44436 | | 29d. Date signed (Month, Day, Year)
August 17, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ASHVINKUMAR PATEL PRESTON SR II INDUSTRIAL PARK DR 20601 WILDFORD MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27270

| | | | | | |
|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>STANLEY</u> | | 2. Date of Death
Month <u>August</u> Day <u>11</u> Year <u>2000</u> | | 3. Time of Death
<u>3:30pm</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>Johns Hopkins Bayview Medical Center</u> | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>Baltimore</u> |
| Funeral
Director | 5. Social Security Number
<u>213-22-5653</u> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>73</u> Yrs. | 8. Date of Birth (Month, Day, Year)
<u>February 29, 1927</u> | 9. Birthplace (State or Foreign Country)
<u>Tennessee</u> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Maryland</u> | 10b. County
<u>Caroline</u> | 10c. City, Town or Location
<u>Ridgely</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
<u>11679 Eveland Road</u> | | 10f. Zip Code
<u>21660</u> | 10g. Citizen of What Country?
<u>United States</u> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>1946-</u>
If Yes, Give Year or Dates: <u>1949</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u></u> |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>7</u> College (1-4or 5+) <u></u> | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Food Processor</u> | | 16b. Kind of Business/Industry
<u>Cannery</u> | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<u>Unknown</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Caroline Hampton</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Savanah Helen Britt Wife</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>11679 Eveland Road, Ridgely, Maryland 21660</u> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u></u> | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Maryland Eastern Shore Veterans Cemetery</u> | | 20c. Location - City or Town, State
<u>Beulah, Maryland</u> |
| | 21. Signature of Funeral Service Licensee
<u>Paul Guarino</u> | | 22. Name and Address of Facility
<u>Moore Funeral Home, P.A.</u>
<u>12 South Second Street, Denton, Maryland 21629</u> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>BACTERIAL PERITONITIS</u>
<u>PERFORATED BOWEL</u>
<u>CORONARY ARTERY DISEASE, HYPERTENSION, ANEMIA</u> | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u></u> | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) <u></u> 28b. Time of Injury <u>M</u> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how Injury occurred <u></u> | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u> | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u> | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<u>Paul Guarino MD</u> | | | | | |
| 29c. License number
<u>21006</u> | | | | | |
| 29d. Date signed (Month, Day, Year)
<u>August 15, 2000</u> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>PAUL GUARINO MD, 7940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 16 2000</u> | | | | | |
| 32. Registrar's Signature
<u>P. Sparks</u> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27271

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER LEON BOSLEY

2. Date of Death
Month Day Year
August 13, 20003. Time of Death
12:51 A. M.

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

220 30 8082

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
JULY 1 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

322 BARNARD STREET

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CORPORATE MANAGER SAFETY

16b. Kind of Business/Industry

KELLY SPRINGFIELD TIRE

17. Father's Name (First, Middle, Last)

HAROLD BOSLEY

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY SMITH

19a. Informant's Name/Relationship (Type, Print)

JOAN BOSLEY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 BARNARD ST., FROSTBURG, MD 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FROSTBURG MEMORIAL PARK

Date

8/16/00

20c. Location - City or Town, State

FROSTBURG, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Ventricular fibrillation

Due to (or as a consequence of):

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Myocardial infarction

Due to (or as a consequence of):

Minutes.

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic valve prosthesis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

RELEASED

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pete Halmos MD.

29c. License number

D04961

29d. Date signed (Month, Day, Year)

August 14, 2000.

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

P. HALMOS 302 SCHLEY ST. Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Pete Halmos

State Registrar

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Physician
/Medical
Examiner

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WALTER BOSLEY 220-30-8082

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27272

Amendment item #23A, QACHD, 8/8/00, TW

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>William Morris Brulle</i> | | 2. Date of Death
Month <i>July</i> Day <i>29</i> Year <i>2000</i> | | 3. Time of Death
<i>9:16pm</i> |
| | 4e. Facility Name (If not institution, give street and number)
<i>University of Maryland Medical System Baltimore</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
<i>212-01-5877</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>93</i> Yrs. | 8. Date of Birth (Month, Day, Year)
<i>JULY 20, 1907</i> | 9. Birthplace (State or Foreign Country)
<i>VA.</i> |
| | Usual Residence of Decedent | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>TALBOT</i> | | 10c. City, Town or Location
<i>EASTON</i> | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
<i>28012 OAKLANDS CIRCLE</i> | | 10f. Zip Code
<i>21601</i> | | 10g. Citizen of What Country?
<i>USA</i> | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i>5</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>ARMY OFFICER</i> | | 16b. Kind of Business/Industry
<i>US GOVERNMENT</i> | |
| 17. Father's Name (First, Middle, Last)
<i>WILLIAM HENRY BRULLE</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>ROSE FRANCES STOLL</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>JAMES R. COVEY/NEPHEW</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>16 SOUTH PRESTWICK COURT, DOVER, DE 19904</i> | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>CHESAPEAKE CREMATION CTR</i> | | 20c. Location - City or Town, State
<i>8-02-00 STEVENSVILLE, MD</i> | |
| 21. Signature of Funeral Service Licensee
<i>Joseph M. Ostrowski</i> | | 22. Name and Address of Facility
<i>FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST. EASTON, MD 21601</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Aspiration</i> Terminal Aspiration
Due to (or as a consequence of):
<i>b. Subdural Hematoma</i>
Due to (or as a consequence of):
<i>c. Acute Renal Failure</i>
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
<i>1 hour</i>
<i>4 DAYS</i>
<i>4 DAYS</i> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Dr. H. H. H.</i> | | 29c. License number
<i>P13140</i> | |
| 29d. Date signed (Month, Day, Year)
<i>8/1/00</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Ronald J. Polinsky Jr, 22 South Greene St. Baltimore, Maryland 21201</i> | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 08 2000</i> | | 32. Registrar's Signature
<i>Penner B. Sparks</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27273

| | | | | | | | | | | |
|--|---|--|--|---|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michael E. Caldwell | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | | | 3. Time of Death
9:39 AM | |
| | 4a. Facility Name (If not institution, give street and number)
1005 Jigger Ct. | | | | 4b. City, Town, or Location of Death
Annapolis | | | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
253-48-7733 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 26, 1933 | | 9. Birthplace (State or Foreign Country)
California | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1005 Jigger Ct. | | | | 10f. Zip Code
21401 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1956-1958 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
4 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chemical Engineer | | | | 16b. Kind of Business/Industry
Engineering | | | | 17. Father's Name (First, Middle, Last)
Rex S. Caldwell | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth S. Chase | | | | 19a. Informant's Name/Relationship (Type, Print)
Shirley Caldwell/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1005 Jigger Ct. Annapolis, MD 21401 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Crematory | | | | 20c. Date
Aug. 14, 2000 | |
| | 20d. Location - City or Town, State
Brentwood, MD | | | | 21. Signature of Funeral Service Licensee
Todd E. Liller | | | | 22. Name and Address of Facility
John M. Taylor Funeral Home
147 Duke of Gloucester St. Annapolis, MD 21401 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Heart Disease
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
William P. Jones, MD Deputy | | | | 29c. License number
D 06054 | | | | 29d. Date signed (Month, Day, Year)
8/11/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William P. Jones, MD 695 America 21035 | | | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
B. Sparks | | |

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27274

Amended item#5 08/23/2000 FCHD,KS Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Kenneth Reno Cecil | | 2. Date of Death
Month Day Year
Aug 12 2000 | | 3. Time of Death
0700 |
| 4a. Facility Name (If not institution, give street and number)
St. Agnes 900 Caton Ave | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death |
| 5. Social Security Number
216-86-1057 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
61 Yrs. | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1938 | 9. Birthplace (State or Foreign Country)
Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State
Maryland | 10b. County | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number
6802 Lenburn Road | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Manager | | 16b. Kind of Business/Industry
Government | | |
| 17. Father's Name (First, Middle, Last)
Wilbur Thomas Cecil, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith Violet Fogle | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Evonne V. Baldoni, Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6025 Montgomery Street, Baltimore, Md. 21207 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery, Aug. 16, 2000 | | 20c. Location - City or Town, State
Frederick, Maryland |
| 21. Signature of Funeral Service Licensee
Richard E. Gray M00255 | | 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home
106 East Church St., Frederick, Md. 21701 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cardiogenic Shock
Due to (or as a consequence of):
b. Bradycardia
Due to (or as a consequence of):
c. Ischemic Cardiomyopathy
Due to (or as a consequence of):
d. Myocardial Infarctions | | | | Approximate Interval Between Onset and Death
minutes
hour
years
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes
End Stage Renal Disease | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier
Shawn Jeffallano | | 29c. License number
F-12599 | | 29d. Date signed (Month, Day, Year)
August 12 2000 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
900 Caton Avenue, Baltimore Maryland 21227 | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
B. Spaul | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#23a perPHYG786 8/29/2000 EW

Certificate of Death

Reg. No. 001 27275

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles Joseph Cliff, Sr. | | | | 2. Date of Death
Month Day Year
April 30, 2000 | | 3. Time of Death
10:45AM | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
092-03-4900 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 4, 1912 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8513 Rayburn Road | | 10f. Zip Code
20817 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: World War II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Musician/Composer | | 16b. Kind of Business/Industry
Music Business | | | | |
| 17. Father's Name (First, Middle, Last)
Horace Greely Cliff | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Julia Ruggiero | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charles Joseph Cliff, Jr./Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1112 North Tuckahoe Street, Falls Church, VA 22046 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | Data
May 2, 2000 | | 20c. Location - City or Town, State
Bethesda, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Robert A. Pumphrey</i> | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. Pneumonia ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. ASPIRATION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
- CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION
- GASTROINTESTINAL BLEEDING
- URINARY TRACT INFECTION. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Describe how injury occurred | | 28c. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Dr. Woodward</i> | | 29c. License number
D. 17656 | | 29d. Date signed (Month, Day, Year)
04/30/00 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
TIPAPORN WOODWARD, M.D. 5530 WISCONSINE AVE. #550 CHEVY CHASE, MD 20815 | | 31. Data filed (Month, Day, Year)
MAY 02 2000 | | 32. Registrar's Signature
<i>Denise G. Sparks</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Cliff, Charles 10:45am
expired 4/30/2000
Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27276

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES CEPHAS | | | | 2. Date of Death
Month Day Year
3-14-00 | | 3. Time of Death
4:35 AM. | |
| | 4a. Facility Name (If not institution, give street and number)
MALLARD BAY 520 GLENBURN AVE. | | | | 4b. City, Town, or Location of Death
CAMBRIDGE | | 4c. County of Death
DORCHESTER | |
| Funeral
Director | 5. Social Security Number
222-07-4368 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
5-14-1913 | |
| | 9. Birthplace (State or Foreign Country)
DELAWARE | | 10a. State
DELAWARE | | 10b. County
SUSSEX | | 10c. City, Town or Location
SEAFORD | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
8 A CHANDLER HEIGHT | | 10f. Zip Code
19973 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CONSTRUCTION | | 16b. Kind of Business/Industry
JAMES HILL CONCRETE WORK | | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE CEPHAS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BLANCHE CANNON | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ANNA JONES | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8A CHANDLER HEIGHT SEAFORD DEL. 19973 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CALVARY | | Date
3-18-00 | | 20c. Location - City or Town, State
CONCORD DELAWARE | |
| | 21. Signature of Funeral Service Licensee
CLARENCE E. YOUNGS | | | | 22. Name and Address of Facility
YOUNGS FUNERAL HOME INC. 308 N. FRONT SEAFORD DEL. 19973 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Heart Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death
5 years | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
W. H. H. MD | | 29c. License number
D 47924 | | 29d. Date signed (Month, Day, Year)
3/21/2000 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NOMAN THAWY 300 AURORA STREET CAMBRIDGE MD 21613 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 28 2000 | | 32. Registrar's Signature
[Signature] | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27277

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene Elizabeth Coppage

2. Date of Death

Month Day Year
Aug. 11, 2000

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

222-14-3029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9-15-1922

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

DE

10b. County

Kent

10c. City, Town or Location

Dover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

299 Richard Bassett Road

10f. Zip Code

19904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Special education teacher

16b. Kind of Business/Industry

Elementary Education

17. Father's Name (First, Middle, Last)

Hartzell Walker

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Toomey

19a. Informant's Name/Relationship (Type, Print)

Hartzell E. Coppage/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

532 Sweeney Circle, Forest, VA 24551

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Odd Fellows Cemetery

Date

8-18-00

20c. Location - City or Town, State

Seaford, DE

21. Signature of Funeral Service Licensee

John A. Cranston

22. Name and Address of Facility

Pippin Funeral Home

119 W. Cam-Wyo Ave, Wyoming, DE 19934

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Congestive heart failure

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast cancer

Colon cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Atkins 1104 Westbury Drive Salisbury MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

[Signature]

ORIGINAL

IRENE WALKER COPPAGE
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27278

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Lou Dougherty | | | | 2. Date of Death
Month Day Year
August 6, 2000 | | 3. Time of Death
10:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | | |
| Funeral
Director | 5. Social Security Number
213-38-1486 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 59 | | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1940 | | |
| | 9. Birthplace (State or Foreign Country)
PA. | | 10a. State
MD. | | 10b. County
Frederick | | 10c. City, Town or Location
Middletown | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8219 Old Hagerstown Rd. | | 10f. Zip Code
21769 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | 16b. Kind of Business/Industry
own home | | | |
| 17. Father's Name (First, Middle, Last)
Alexander Buchus | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Wilson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Francis E. Dougherty (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8219 Old Hagerstown Rd., Middletown, MD. 21769 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory | | Date
8/9 | | 20c. Location - City or Town, State
Smithsburg, MD. | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Candida sepsis</u>
Due to (or as a consequence of):
b. <u>leuko pneumonia</u>
Due to (or as a consequence of):
c. <u>chemo therapy</u>
Due to (or as a consequence of):
d. <u>extensive endometrial CA</u> | | | | | | | | Approximate Interval Between Onset and Death
2 days
2 weeks
3 weeks
2 mo | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Diabetes</u> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D14426 | | 29d. Date signed (Month, Day, Year)
Aug 7, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P G Trausch 501 W 7th St Frederick MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 11 2000 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27279

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carolyn Courtney Dock | | | | 2. Date of Death
Month Day Year
August 14, 2000 | | 3. Time of Death
3:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
8285 Black Haw Court | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
547-44-7817 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 20, 1935 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
8285 Black Haw Court | | 10f. Zip Code
21701 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
self | | | | 16b. Kind of Business/Industry
homemaker | | 17. Father's Name (First, Middle, Last)
John Haley Bierer | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Florence Courtney | | | | 19a. Informant's Name/Relationship (Type, Print)
Amy Johnson, daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3612 Glenoble Court, Jefferson, Maryland 21755 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory | | 20c. Location - City or Town, State
Smithsburg, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Kevin M. Berger | | | | 22. Name and Address of Facility
Keeney and Basford Funeral Home
M00999 106 East Church Street, Frederick, MD 21701 | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Myocardial Infarction
Due to (or as a consequence of):
Coronary artery disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
minutes
months - years | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
8/16/2000 | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
M | | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier
Ronald Cooper MD | | | | 29c. License number
00052484 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
8/16/00 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ronald Cooper 915 Toll House Avenue Frederick, Maryland | | | |
| | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | | | 32. Registrar's Signature
B. Spaul | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27280

| | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|--------------------------------------|---|---|--|--|---|---|--|--|-----------------------|----------------|--------------------------|----------------|-------------------------------|----------------|-----------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ERICK G. DEFFINBAUGH | | | | 2. Date of Death
Month Day Year
AUGUST 16 2000 | | 3. Time of Death
12:20 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
216-76-1402 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
34 Yrs. | | 8. Date of Birth
Month Day Year
Mar 29, 1966 | | | | | | | | | | | | | |
| | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
none | | 16b. Kind of Business/Industry
n/a | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Gordon Deffinbaugh | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary F Kimmell | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Swanger mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13221 Meders Lane N.E.; Cumberland MD 21502 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Par8/20/ | | 20c. Location - City or Town, State
Cumberland, MD | | 20d. Date
8/17/2000 | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
James F. Scarpelli | | | | 21b. Address of Funeral Home, P.A.
Cumberland, MD 21502 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Adult Respiratory Distress Syndrome</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. PERITONITIS</td> <td>unknown</td> </tr> <tr> <td>c. ISCHEMIC BOWEL</td> <td>unknown</td> </tr> <tr> <td>d. Acute renal failure</td> <td>unknown</td> </tr> <tr> <td colspan="2">Paul A. Aug 17, 2000</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Adult Respiratory Distress Syndrome | Approximate Interval Between Onset and Death | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. PERITONITIS | unknown | c. ISCHEMIC BOWEL | unknown | d. Acute renal failure | unknown | Paul A. Aug 17, 2000 | |
| | Immediate Cause (Final disease or condition resulting in death) | a. Adult Respiratory Distress Syndrome | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. PERITONITIS | unknown | | | | | | | | | | | | | | | | | |
| | | c. ISCHEMIC BOWEL | unknown | | | | | | | | | | | | | | | | | |
| d. Acute renal failure | | unknown | | | | | | | | | | | | | | | | | | |
| Paul A. Aug 17, 2000 | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
OSTEOGENESIS IMPERFECTA
MALNUTRITION, chronic | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Paul A. | | | | 29c. License number
D23167 | | 29d. Date signed (Month, Day, Year)
Aug 17, 2000 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Juan Arrisueno M.D. 902 Seton Drive Cumberland MD 21502 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
Paul A. | | | | | | | | | | | | | | | | | | |

James E. Jones

Aug 18 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27281

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY ENGELS | | | | 2. Date of Death
Month 08 Day 03 Year 2000 | | 3. Time of Death
0635 | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEN COR | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
579-16-3620 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 15, 1916 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
114 East Lake Drive | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Intelligence Analyst | | 16b. Kind of Business/Industry
U.S. Navy | | | |
| | 17. Father's Name (First, Middle, Last)
William Curran | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Doris Melville Chane | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
James W. Engels / stepson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13301 Ardennes Ave. Rockville, MD 20851 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ft. Lincoln Crematory | | 20c. Date
8-7-00 | | 20d. Location - City or Town, State
Brentwood, MD. | |
| | 21. Signature of Funeral Service Licensee
E. Brian Powell | | 22. Name and Address of Facility
John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Repetitive Aspiration pneumonia
Due to (or as a consequence of): Stroke

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
As per tumor
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
3 mo | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | | | 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
John M. Taylor | | 29c. License number
0 21438 | | 29d. Date signed (Month, Day, Year)
Aug 03, 2000 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MILITARY LAFAYETTE, MD 20686-1077 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 08 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0055.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

00000000000000000000000000000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27282

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clayton O. Eakle

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veteran's Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

578 20 1034

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
02/07/1919

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

940 Tidewater Grove Court

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1943-

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Federal Employee

16b. Kind of Business/Industry

Dept of the Navy

17. Father's Name (First, Middle, Last)

Clayton O. Eakle, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bowes

19a. Informant's Name/Relationship (Type, Print)

Mary Patricia Collier/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

940 Tidewater Grove Ct., Annapolis MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

8/17/00

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee

▶ Michael Wilhelm Wagner

22. Name and Address of Facility

Advent Funeral & Cremation Services

Annapolis MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

5-10 minutes

Due to (or as a consequence of):

b. ATHEROSCLEROTIC HEART DISEASE YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI-INFARCT DEMENTIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ J. Laund

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

August 15 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKUMAR J PATEL

PRESTON SB II 6 Industrial Park Dr LINDSBURG MD 20601

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. Sparks

State
Registrar

CLAYTON O. EAKLE AUGUST 14, 2000 7:30PM,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

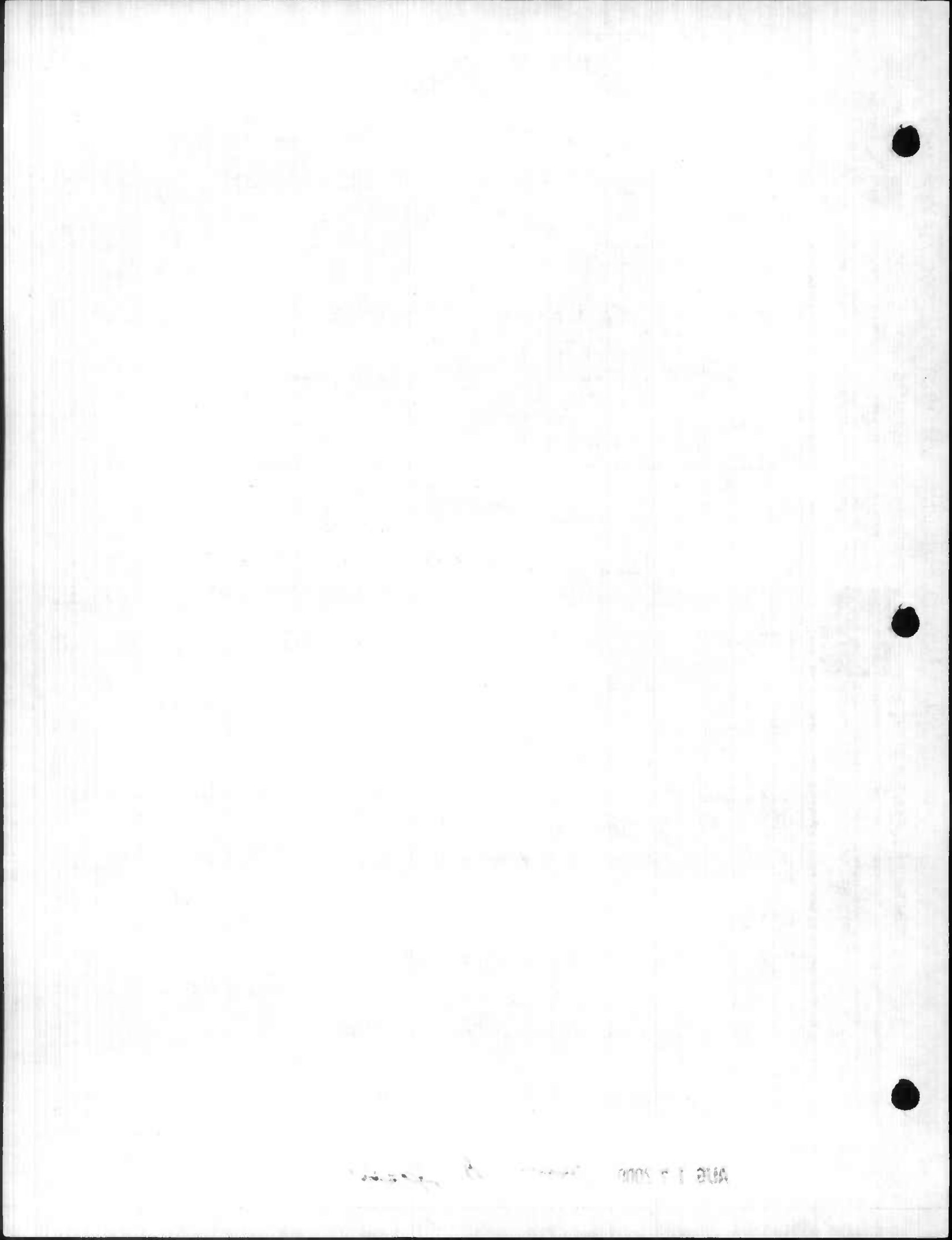
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death

ALBERT DANIEL EPLING AUG. 12 2000 0822

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

213-44-6895 1 M 2 F 55 Yrs. DEC. 31, 1944 MARYLAND

Usual Residence of Decedent

10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits

MARYLAND WORCESTER BERLIN 1 Yes 2 No

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

41 ROBINHOOD TRAIL, OCEAN PINES 21811 USA

11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No 1 Yes 2 No Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementary/Secondary (0-12) College (1-4 or 5+) PAINTER AUTOMOBILE

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

PHILLIP FRANK EPLING VILLA MARIE SPRINKLE

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

JEAN A. EPLING/WIFE 41 ROBINHOOD TRAIL, BERLIN, MARYLAND 21811

20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 8/13/00 DELMAR, DELAWARE

21. Signature of Funeral Service Licensee 22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient 3 OOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined M 1 Yes 2 No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN E. HEARNE MD, 106 MILFORD ST., SALISBURY, MD 21801

31. Date filed (Month, Day, Year) 32. Registrar's Signature

AUG 15 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27284

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEOLON ANDREW EVANS | | | | 2. Date of Death
Month 8 - Day 9 - Year 2000 | | 3. Time of Death
6:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
2780 HICKMAN LANE | | | | 4b. City, Town, or Location of Death
NANTICOKE | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
215-26-5636 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
5-19-31 | | 9. Birthplace (State or Foreign Country)
MD. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD. | | 10b. County
WICOMICO | | 10c. City, Town or Location
NANTICOKE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2780 - HICKMAN LANE | | | | 10f. Zip Code
21840 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1949-54 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CUSTODIAN | | 16b. Kind of Business/Industry
BOARD OF EDUCATION | | |
| 17. Father's Name (First, Middle, Last)
ANDREW WILLIAM EVANS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMMA COLLINS EVANS | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
THELMA EVANS (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2780 HICKMAN LANE, NANTICOKE, MD. 21840 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD. VA CEMETARY | | Date
8-14-2000 | | 20c. Location - City or Town, State
BEULAH, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
BENNIE SMITH F/H
917-W. ISABELLA ST. SALISBURY, MD. 21801 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
ASCA D.
Due to (or as a consequence of):
Upper Gastrointestinal Bleed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Congestive Heart Failure
Due to (or as a consequence of):

 | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 MD DME | | | | 29c. License number
D0054127 | | 29d. Date signed (Month, Day, Year)
8/14/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alon DAVIS 3 Bistate Blvd Delmar MD 21875 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27285

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FLORINE B. GROSS | | | | 2. Date of Death
Month Day Year
AUG. 12 2000 | | | | 3. Time of Death
1625 | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
219-30-4283 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 15 1929 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | 10a. State
MARYLAND | | | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ANNAPOLIS | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
164 O'BERRY COURT | | | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
NONE | | | |
| 17. Father's Name (First, Middle, Last)
CHARLES KYLER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CARRIE HALL | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOSEPH E. GROSS (HUSBAND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
164 O'BERRY CT. ANNAPOLIS, MD. 21401 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANNAPOLIS MEM. GARDENS | | | Date
8/18/00 | | 20c. Location - City or Town, State
ANNAPOLIS, MD. | |
| 21. Signature of Funeral Service Licensee
Larry H. Reese M00483 | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Acute Respiratory Distress Syndrome
Due to (or as a consequence of):
Pneumocystis Carinii Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Renal Insufficiency
Anemia
Hypoalbuminemia | | | | | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Insufficiency
Anemia
Hypoalbuminemia | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
P55187 | | |
| 29d. Date signed (Month, Day, Year)
August 14, 2000 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Amee Yu 64 Franklin Street, Annapolis, MD 21401 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
[Signature] | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item#2 per doctor 08/24/2000 Certificate of Death FCHD KS

Reg. No.

00 27286

| | | | | | | |
|--|---|--|---|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John W. Griffith | | 2. Date of Death
Month August Day 17 Year 2000 | | 3. Time of Death
07:07 | |
| | 4a. Facility Name (If not institution, give street and number)
Washington County Hospital | | 4b. City, Town, or Location of Death
Hagerstown | | 4c. County of Death
Washington | |
| Funeral
Director | 5. Social Security Number
577-42-0063 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Apr. 28, 1931 |
| | 9. Birthplace (State or Foreign Country)
D.C. | | | | | |
| Usual Residence of Decedent | | | | | | |
| 10a. State
Maryland | | 10b. County
Washington | | 10c. City, Town or Location
Hagerstown | | 10d. Inside City Limits
1 Yes 2 No |
| 10e. Street and Number
750 Dual Highway | | | 10f. Zip Code
21740 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Electronics Salesman | | 16b. Kind of Business/Industry
Sales | | |
| 17. Father's Name (First, Middle, Last)
John W. Griffith Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise E. Robertson | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Eleanor L. Rickard (Sister) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 Victor Drive, Thurmont, Maryland 21788 | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Mem. Gardens | | Date
8/21/00 | 20c. Location - City or Town, State
Frederick, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
615 EAST MAIN ST., THURMONT, MD 21788 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
PNEUMONIA (BILATERAL) | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
DEMENTIA
CHRONIC ANEMIA | | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | | |
| 24a. Was an autopsy performed?
1 Yes 2 No | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D52055 | | 29d. Date signed (Month, Day, Year)
8-17-00 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ZUBAIR M. SYED 368 MILL ST. HAGERSTOWN, MD 21740 | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

John W. Griffith

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27287

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SISTER LEO GARDNER

2. Date of Death

AUGUST 15, 2000

3. Time of Death

1:15 P.M.

4a. Facility Name (If not institution, give street and number)

VILLA ST. MICHAEL

4b. City, Town, or Location of Death

EMMITSBURG

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

577-28-5597

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV. 23, 1921

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

FREDERICK

10c. City, Town or Location

EMMITSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

333 S. SETON AVE.

10f. Zip Code

21727

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

RELIGIOUS COMMUNITY
DAUGHTER OF CHARITY

17. Father's Name (First, Middle, Last)

FRANCIS I. V. GARDNER

18. Mother's Name (First, Middle, Maiden Surname)

MARIE BRUEN

19a. Informant's Name/Relationship (Type, Print)

SISTER CAMILLA HARANT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 S. SETON AVE., EMMITSBURG, MD. 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ST. JOSEPH'S

Date

8/19/2000

20c. Location - City or Town, State

EMMITSBURG, MD. 21727

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERA HOME

210 W. MAIN ST., EMMITSBURG, MD. 21727

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Exsanguination
Disseminated Intravascular Coagulation
7 weeksSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
Recurrent Metastatic Breast Cancer
5 yrs.Due to (or as a consequence of):
Remote Breast Cancer
35 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Card compression second to
metastatic disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bonita Krenzel-Porter

29c. License number

H44057

29d. Date signed (Month, Day, Year)

AUGUST 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonita Krenzel-Porter

52 WATER ST
THURMONT, MD 21727

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27288

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|-------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORIS G. GRAY | | | | 2. Date of Death
Month Day Year
August 13, 2000 | | 3. Time of Death
3:05 PM | |
| | 4a. Facility Name (If not institution, give street and number)
25485 Harcum Wharf Road | | | | 4b. City, Town, or Location of Death
Eden | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
225-28-1976 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 18, 1913 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Wicomico | | 10c. City, Town or Location
Eden | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
25485 Harcum Wharf Rd. | | | | 10f. Zip Code
21822 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | | 16b. Kind of Business/Industry
Health Care | | |
| | 17. Father's Name (First, Middle, Last)
Frederick B. Gerald | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Blades | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Judy A. Gray/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25485 Harcum Wharf Rd., Eden, MD 21822 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Park | | 20c. Location - City or Town, State
Salisbury, MD | | 20d. Date
8/16/00 | |
| | 21. Signature of Funeral Service Licensee
Keith R. Downey | | | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Asystole
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):
c. Atherosclerotic heart disease
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic renal failure | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number
D19289 | | 29d. Date signed (Month, Day, Year)
8/14/00 | |
| | 29b. Signature and title of certifier
[Signature] | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chapman L. Rank MD 400 Eastern Shore Drive Salisbury MD 21801 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
[Signature] | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27289
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|-----------------------------|---|--|----------------|--|----|--|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robertson C. Hesse | | | | 2. Date of Death
Month Day Year
August 2, 2000 | | 3. Time of Death
7:45 am | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
101 Park Place | | | | 4b. City, Town, or Location of Death
Severna Park | | 4c. County of Death
Anne Arundel | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
218-18-0861 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Mar 17, 1917 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Anne Arundel | 10c. City, Town or Location
Severna Park | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | 10e. Street and Number
101 Park Place | | | 10f. Zip Code
21146 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Attorney | | 16b. Kind of Business/Industry
Legal | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles H. Pierce | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Clemens | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Hesse/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
101 Park Place Severna Park, MD 21146 | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
Aug 3 2000 | | 20c. Location - City or Town, State
Baltimore, MD | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death—Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>PULMONARY FAILURE</u></td> <td>Approximate Interval Between Onset and Death
<u>10 YRS</u></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <u>COPD</u></td> <td></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <u>PULMONARY FAILURE</u> | Approximate Interval Between Onset and Death
<u>10 YRS</u> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>COPD</u> | | c. | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) | a. <u>PULMONARY FAILURE</u> | Approximate Interval Between Onset and Death
<u>10 YRS</u> | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>COPD</u> | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D08118 | | 29d. Date signed (Month, Day, Year)
8/3/2000 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stanley Watkins MD
900 Best Gate Rd. Ste 300, Annapolis MD 21401 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 07 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27290

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES ALBERT HILL SR

2. Date of Death

8 14 2000 0308

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

213-22-8383

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 2, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6137 Steve Street

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
7College (1-4 or 5+)
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Mason Wright Hill Sr

18. Mother's Name (First, Middle, Maiden Surname)

Mary Emily Moore

19a. Informant's Name/Relationship (Type, Print)

Charles A. Hill Jr/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1125 Central St., Oshkosh, WI 54901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

8/17/00

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

David H. Thompson

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Refractory Ventricular Arrhythmia (fatal)
Due to (or as a consequence of):
Coronary artery disease
Due to (or as a consequence of):
Coronary artery disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Ruffetto

29c. License number

20441

29d. Date signed (Month, Day, Year)

8-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Ruffetto 400 Eastern Shore Dr, Salisbury, Md, 21804

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

S. Sparks

State
Registrar

Charles Hill 213 22 8383

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27291

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAE BROWN ISCHER | | | | | | 2. Date of Death
Month Day Year
August 19 2000 | | 3. Time of Death
5:20 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
Caroline Nursing Home, Inc. | | | | | | 4b. City, Town, or Location of Death
Denton | | 4c. County of Death
Caroline | | | |
| Funeral
Director | 5. Social Security Number
220-26-3835 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 8, 1903 | | 9. Birthplace (State or Foreign Country)
Del. | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
CAROLINE | | 10c. City, Town or Location
FEDERALSBURG | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
407 WEST CENTRAL AVE | | | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | | 16b. Kind of Business/Industry
HOUSEWIFE | | | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE BROWN | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
AUDREY YOUNG | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
SHARON COWLEY-FRIEND | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
520 KEV AVE DENTON, MD 21629 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Cemetery | | 20c. Location - City or Town, State
8/22/00 FEDERALSBURG MD | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
WILLIAMSON FUNERAL HOME
FEDERALSBURG, MD 21632 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death
1 week | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Acute Renal Failure | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
4D D 31376 | | 29d. Date signed (Month, Day, Year)
8-21-00 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Siles 920 Market St Denton MD | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 23 2000 | | | | 32. Registrar's Signature
 | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27292

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ESTELLE K. JONES | | | | 2. Date of Death
Month Day Year
AUG. 2 2000 | | | | 3. Time of Death
0750 | |
| | 4a. Facility Name (If not institution, give street and number)
ANNE ARUNDEL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
ANNAPOLIS | | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
262-76-5140 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
55 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 7 1945 | | 9. Birthplace (State or Foreign Country)
GEORGIA | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ANNAPOLIS | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
1105 PRESIDENT STREET | | | | 10f. Zip Code
21403 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4 or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPING | | | | 16b. Kind of Business/Industry
ANNE ARUNDEL MEDICAL CENTER | | | | 17. Father's Name (First, Middle, Last)
WILLIE KING | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE MAE WALKER | | | | 19a. Informant's Name/Relationship (Type, Print)
JOHN R. KING (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1105 PRESIDENT ST. ANNAPOLIS, MD. 21403 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANNAPOLIS MEM. GARDENS | | | | 20c. Location - City or Town, State
8/11/00 ANNAPOLIS, MD. | |
| | 21. Signature of Funeral Service Licensee
Larry H. Reese M00483 | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute pulmonary failure
Due to (or as a consequence of):
lung atelectasis
Due to (or as a consequence of):
esophageal tracheal fistula
Due to (or as a consequence of):
perforated carcinoma of esophagus | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Physician
/Medical
Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Dr. A. Philp M.D. | | | | 29c. License number
004453 | |
| | 29d. Date signed (Month, Day, Year)
8/2/00 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRAD A. Philp M.D., 1633A Rinehart Dr. Anne Arundel | | | | 31. Date filed (Month, Day, Year)
AUG 07 2000 | |
| | 32. Registrar's Signature
James H. Smith | | | | 33. State Registrar
AUG 07 2000 | | | | 34. State Registrar | |

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State of Maryland / Department of Health and Mental Hygiene 00 27293

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|---|---|--|--|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELIZABETH ELLIS JACKSON | | | | | | 2. Date of Death
Month Day Year
August 8 2000 | | 3. Time of Death
1:55 p.m. | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Wicomico Nursing Home | | | | | | 4b. City, Town, or Location of Death
Salisbury | | 4c. County of Death
Wicomico | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217-28-4840 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 2, 1909 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Hebron | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| 10e. Street and Number
7615 Rockawalkin Road | | | | 10f. Zip Code
21830 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Trimmer | | | 16b. Kind of Business/Industry
Shirt Factory | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Oscar Fowler Ellis | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Gertrude Howard | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret J. Hayman/Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7615 Rockawalkin Rd., Hebron, MD 21830 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hebron Cemetery | | | 20c. Date
8/12/00 | | 20d. Location - City or Town, State
Hebron, MD | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
Keith P. Harvey | | | | | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>Arteriosclerotic Cardiovascular Disease</td> <td>Approximate Interval Between Onset and Death
5 yrs</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | Arteriosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death
5 yrs | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | | | |
| Immediate Cause (Final disease or condition resulting in death) | Arteriosclerotic Cardiovascular Disease | Approximate Interval Between Onset and Death
5 yrs | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus Type II
Cerebrovascular Thrombosis - Stroke
Degenerative Osteoarthritis | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Gregorio B. Belloso M.D. | | | | | | 29c. License number
D 29505 | | 29d. Date signed (Month, Day, Year)
8-9-2000 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregorio Belloso, M.D. 5302 Chinaberry Drive Salisbury, MD 21801 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 10 2000 | | | 32. Registrar's Signature
B. Sparks | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a,27 per MEOG788 10/12/2000 EW

Certificate of Death

Reg. No.

00 27294

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

| | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DEBBIE ANN JONES | | | | 2. Date of Death
Month AUGUST Day 22 Year 2000 | | 3. Time of Death
1:04 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
221-44-5520 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
38 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
2/13/62 | 9. Birthplace (State or Foreign Country)
VA. | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD. | | 10b. County
WICOMICO | | 10c. City, Town or Location
DELMAR | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
201- SPRUCE STREET | | | | 10f. Zip Code
21875 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPER | | 16b. Kind of Business/Industry
BEST WESTERN HOTEL | | | |
| 17. Father's Name (First, Middle, Last)
JOHN HENRY WARD | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SHIRLEY FAULKNER WARD | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOHN WARD - BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
201-SPRUCE ST. DELMAR, MD. 21875 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CAPITOL CREMATORY | | 20c. Location - City or Town, State
8/29/2000 DOVER, DE. | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
BENNIE SMITH FH
917 W. ISABELLA ST. SALISBURY, MD. 21801 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

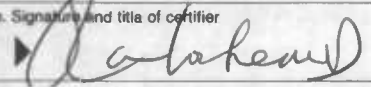
Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 23, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 28 2000 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27295

| | | | | | | | | |
|--|---|---|---|--|---|--|--|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Lawson Jump, Jr. | | | | 2. Date of Death
Month Day Year
Aug. 12, 2000 | | 3. Time of Death
1013 | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
218-01-9557 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
January 27, 1919 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
10774 Greensboro Road | | | | 10f. Zip Code
21629 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1944-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 HS Grad
College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | 16b. Kind of Business/Industry
Automobile Company | | |
| 17. Father's Name (First, Middle, Last)
Rev. William Lawson Jump, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cathell Ward | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marguerite P. Jump Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10774 Greensboro Road, Denton, Maryland 21629 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Denton Cemetery | | Date
8/15/00 | | 20c. Location - City or Town, State
Denton, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Respiratory failure
Due to (or as a consequence of):
a. Aspiration pneumonia
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Urinary tract infection
Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
2 days
3 days
3 days
5 days | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ischemic Hepatitis
acute renal failure | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Haron Laura Jin | | | | 29c. License number
D0055484 | | 29d. Date signed (Month, Day, Year)
8-12-2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Laura Jin, M.D., 219 South Washington Street, Easton, Maryland 21629 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

00-4526-009

ALEXANDER J JANOSI Jr.

JVM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27296

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alexander J. Janosi

2. Date of Death
Month Day Year

AUGUST 12, 2000

3. Time of Death

9:22 P.M.

4a. Facility Name (If not institution, give street and number)

infront of 11870 Harry G. TRUMAN ROAD

4b. City, Town, or Location of Death

LUSBY

4c. County of Death

CALVERT

Funeral
Director

5. Social Security Number

714 05 4531

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 12, 1913

9. Birthplace (State or Foreign)

New Jersey

Usual Residence of Decedent

10a. State
Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11870 H. G. Truman Road

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

station engineer

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Alexander J. Janosi, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schaefer

19a. Informant's Name/Relationship (Type, Print)

James F. Gatton - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 3544 Reston, VA 20195

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Middleham Cemetery

Date

Aug 18, 2000

20c. Location - City or Town, State

Lusby Maryland

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

27. Manner of Death

☐ Natural☒ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

8/12/00

28b. Time of Injury

9:21 P M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

PEDESTRIAN STRUCK BY AUTO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HARRY G. TRUMAN ROAD

LUSBY, MD

29e. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J.M. Janosi

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. THUS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Rausch

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27297

| | | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES H. KYLER | | | | 2. Date of Death
Month Day Year
AUGUST 03, 2000 | | | | 3. Time of Death
10:41 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
106 BARK COURT | | | | 4b. City, Town, or Location of Death
ARNOLD | | | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
214-56-0890 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC. 5 1951 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | 10a. State
MARYLAND | | | | 10b. County
ANNE ARUNDEL | | 10c. City, Town or Location
ARNOLD | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
106 BARK COURT | | | | 10f. Zip Code
21012 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1971-72 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DIETARY DEPT. | | 16b. Kind of Business/Industry
CROWNSVILLE STATE HOSPITAL | | | |
| | 17. Father's Name (First, Middle, Last)
OLIVER W. KYLER SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GRACE TYLER | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
GRACE DORSEY (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
106 BARK COURT ARNOLD, MD. 21012 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND VETERAN CEME. | | 20c. Date
8/10/00 | | 20d. Location - City or Town, State
CROWNSVILLE, MD. | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Larry B. Reese M00883 | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Chronic Alcoholism with Fatty metamorphosis of Liver and Seizure Disorder | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Cardiovascular Disease | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
J. Pestaner, MD | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 04, 2000 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 08 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Aug 8 8 00A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27298

| | | | | | | | | | | |
|--|---|---------------------------------|---|--|--|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GLORIA E STELLE KINES | | | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | 3. Time of Death
7:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
10815 Pleasant Walk Road | | | | | | 4b. City, Town, or Location of Death
Myersville | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
214-30-2409 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 6, 1934 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10e. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Myersville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
10815 Pleasant Walk Road | | | | 10f. Zip Code
21773 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
own home | | | |
| 17. Father's Name (First, Middle, Last)
Jacob Huffer | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Boetler | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William H. Kines, Jr. | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10815 Pleasant Walk Rd./ Myersville, MD 21773 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory | | 20c. Location - City or Town, State
8-12=00 Hagerstown, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
<i>Raymond Peterson</i> | | | | 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike/ Frederick, Maryland 21702 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. prob brain metastases
Due to (or as a consequence of):
b. extensive skull cell
Due to (or as a consequence of):
c. ca lung + bone
Due to (or as a consequence of):
d. node, liver & breast
Approximate Interval Between Onset and Death
79 | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
014622 | | 29d. Date signed (Month, Day, Year)
Aug 11, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. Gregory Rausch / 501 West Seventh St./ Frederick, Maryland 21701 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27299
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Sister Vincentine Kelly

2. Date of Death

Month Day Year
Aug. 11, 2000

3. Time of Death

11:00 A.

4a. Facility Name (If not Institution, give street and number)

St. Vincent Care Center

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

5. Social Security Number

214-54-6252

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 18, 1903

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Emmitsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

335 South Seton Avenue

10f. Zip Code

21727

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11 Yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Practical Nursing

16b. Kind of Business/Industry

Religious Community
Daughters of Charity

17. Father's Name (First, Middle, Last)

Michael Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gallagher

19a. Informant's Name/Relationship (Type, Print)

Sister Camilla Harant

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

333 South Seton Avenue, Emmitsburg, MD 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ST. JOSEPH'S CEMETERY 8/14/00

Date

20c. Location - City or Town, State

EMMITSBURG, MD.

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERAL HOME

210 W. MAIN ST., EMMITSBURG, MD. 21727

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Ischemic Bowel
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 mo

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Atherosclerosis
Due to (or as a consequence of):

15 years

c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

15 yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration
Fracture

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bonita Krempel-Porter

29c. License number

#44037

29d. Date signed (Month, Day, Year)

8/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bonita Krempel-Porter

820 WATER ST
THURMONT, MD 21127

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Spack

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27300

Amendment item #8, QACHD, 8/11/00, tw

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Charles E. Knell, Jr. | | | | 2. Date of Death
Month: August Day: 8 Year: 2000 | | 3. Time of Death
1715 | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
215-54-2721 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov 11, 1950
Nov 19, 1950 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Queen Anne's | | 10c. City, Town or Location
Stevensville | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
401 South Lake Court | | 10f. Zip Code
21666 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+): 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mortgage Broker | | 16b. Kind of Business/Industry
Banking | | | | |
| 17. Father's Name (First, Middle, Last)
Charles E. Knell, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jeanne Fitzgerald | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Linda M. Sterling/ Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
401 South Lake Court, Stevensville Md 21666 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation Center 8/9/2000 | | 20c. Location - City or Town, State
Chester, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
<i>Chas. M. L. P. H.</i> | | 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home P.A.
106 Shamrock Rd, Chester MD 21666 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Myocardial Infarction</i>
Due to (or as a consequence of):
b. <i>Ischemic Cardiovascular Disease</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>metastatic Cancer</i> | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier
(Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Curtis Harris MD</i> | | 29c. License number
053306 | | 29d. Date signed (Month, Day, Year)
8/8/00 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Curtis Harris MD 600 Ridgely Ave Ste 231 Annapolis MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 11 2000 | | 32. Registrar's Signature
<i>Beverly B. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27301

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|-------------------------------------|---|--|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eugene Wood Lane | | | | 2. Date of Death
Month Day Year
August 9 2000 | | | | 3. Time of Death
7:45 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Annapolis Nursing and Rehabilitation Center | | | | 4b. City, Town, or Location of Death
Annapolis | | | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
717-12-3853 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 8. Date of Birth
(Month, Day, Year)
October 22, 1910 | | 9. Birthplace (State or Foreign Country)
New Jersey | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Annapolis | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
2658 Queen Anne Circle | | 10f. Zip Code
21403 | | 10g. Citizen of What Country?
United States | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | |
| | 16b. Kind of Business/Industry
Accounting | | 17. Father's Name (First, Middle, Last)
Elmer Lane | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Campbell Lynn | | 19a. Informant's Name/Relationship (Type, Print)
Mary Lynn Chipouras/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2658 Queen Anne Circle Annapolis, MD 21403 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cemetery | | Date
8/11/00 | | 20c. Location - City or Town, State
Yeadon, PA | | 21. Signature of Funeral Service Licensee
Todd Miller | | |
| | 22. Name and Address of Facility
John M. Taylor Funeral Home
147 Duke of Gloucester St. Annapolis, MD 21401 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
5 years | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Paul Berez, MD | | |
| | 29c. License number
D0029571 | | 29d. Date signed (Month, Day, Year)
8/14/00 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Berez, MD 1655 Crofton Blvd. Suite 101 Crofton, MD 21114 | | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
B. Sparks | | |
| | State Registrar | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27302

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|--|--|--|---|----|-------------------|----------------------------------|---|----|----------------------|----------------------------------|-------------------|----|--|----------------------------------|--|----|--|----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joan Phyllis Lawson | | | | 2. Date of Death
Month Day Year
August 10, 2000 | | | | 3. Time of Death
11:30 AM | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Millennium Health & Rehabilitation Center | | | | 4b. City, Town, or Location of Death
Edgewater | | | | 4c. County of Death
Anne Arundel | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-28-1726 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
41 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 3, 1928 | | 9. Birthplace (State or Foreign Country)
England | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Edgewater | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
300 Wilmer Place | | | | 10f. Zip Code
21037 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Factory Worker | | | | 16b. Kind of Business/Industry
Shoes | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Thomas Wilson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Slattery | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Roy L. Lawson/ Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
300 Wilmer Place Edgewater, MD 21037 | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Date
8-12-00 | | 20d. Location - City or Town, State
Alexandria, Virginia | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037 | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Metastatic Cancer</td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death
MORE THAN 1 MONTH</td> </tr> <tr> <td>b.</td> <td>RENAL CELL CARCINOMA</td> <td>Due to (or as a consequence of):</td> <td>MORE THAN 2 YEARS</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Metastatic Cancer | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
MORE THAN 1 MONTH | b. | RENAL CELL CARCINOMA | Due to (or as a consequence of): | MORE THAN 2 YEARS | c. | | Due to (or as a consequence of): | | d. | | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Metastatic Cancer | Due to (or as a consequence of): | Approximate Interval Between Onset and Death
MORE THAN 1 MONTH | | | | | | | | | | | | | | | | | | | | | | |
| | b. | RENAL CELL CARCINOMA | Due to (or as a consequence of): | MORE THAN 2 YEARS | | | | | | | | | | | | | | | | | | | | | | |
| | c. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 50653 | | 29d. Date signed (Month, Day, Year)
8-10-2000 | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GYAN - C. SURANA
5851. Deale Churchton Road. Deale MD. 20751 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27303

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|-------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
So Ja Lee | | | | 2. Date of Death
Month Day Year
08 11 2000 | | | | 3. Time of Death
7:47 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Gilchrist Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
071 48 1713 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth (Month, Day, Year)
02-11-1940 | | 9. Birthplace (State or Foreign Country)
Korea | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Arnold | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
270 Overleaf Drive | | | | 10f. Zip Code
21012 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Asian | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Florist | | | 16b. Kind of Business/Industry
Food Service | | |
| | 17. Father's Name (First, Middle, Last)
Kyoung Neem Yoon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gae Won Ahn | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Chul Woo Lee Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
270 Overleaf Drive Arnold, MD. 21012 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairfax Memorial Park | | Date
08/13/00 | | 20c. Location - City or Town, State
Fairfax, Virginia | | | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Advent Funeral & Cremation SVCS.
7211 Lee Highway Falls Church, Virginia 22046 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Breast Cancer
Due to (or as a consequence of):
Approximate Interval Between Onset and Death
4 years | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
f.
Due to (or as a consequence of):
g.
Due to (or as a consequence of):
h.
Due to (or as a consequence of): | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
D25205 | | 29d. Date signed (Month, Day, Year)
August 12, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley G.B.M.C. 06781 N-Charles St, Balto, md | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

ORIGINAL

[Faint, illegible handwritten marks]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27304

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY ALICE LEJEUNE | | | 2. Date of Death
Month Day Year
August 10, 2000 | | 3. Time of Death
5:20 AM | |
| | 4a. Facility Name (If not institution, give street and number)
812 Gettysburg Ave. | | | 4b. City, Town, or Location of Death
Salisbury | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
217-28-4927 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
September 4, 1932 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Wicomico | 10c. City, Town or Location
Salisbury | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
812 Gettysburg Ave. | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
School Crossing Guard | | 16b. Kind of Business/Industry
Board of Education | | |
| | 17. Father's Name (First, Middle, Last)
Harold Mason | | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Campbell | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Herbert W. Lejeune/Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
812 Gettysburg Ave., Salisbury, MD 21804 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory Gardens | | Date
8/14/00 | 20c. Location - City or Town, State
Hebron, MD | |
| | 21. Signature of Funeral Service Licensee
Keith P. Droney | | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End stage Emphysema
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
Catherine R. Horner | | | | 29c. License number
P45005 | | 29d. Date signed (Month, Day, Year)
8-10-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Catherine R. Horner 1104 Healthway Dr Salisbury MD 21804 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 11 2000 | | 32. Registrar's Signature
B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#23a per PHYG786 8/29/2000 **State of Maryland / Department of Health and Mental Hygiene** 00 27305
 Amended, Item#8, per F.H., TCHD, 7/17/00, sbb **Certificate of Death** Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|---|--|---|--|--|---------------------------|--|---|--|---|
| 1. Decedent's Name (First, Middle, Last)
WILLIAM WHITFIELD LEWIS, JR. | | | | | | 2. Date of Death
Month JULY Day 9 Year 2000 | | 3. Time of Death
1940 | |
| 4a. Facility Name (If not institution, give street and number)
24331 DEEP NECK RD | | | | 4b. City, Town, or Location of Death
ROYAL OAK | | 4c. County of Death
TALBOT | | | |
| 5. Social Security Number
188-34-1024 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
58 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours | If Under 24 Hrs.
Min. | 8. Date of Birth (Month, Day, Year)
Aug. 28, 1941 | | 9. Birthplace (State or Foreign Country)
PA |
| Usual Residence of Decedent
Sept. 28, 1941 | | | | | | | | | |
| 10a. State
MD | | 10b. County
TALBOT | | 10c. City, Town or Location
ROYALOAK | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
24331 DEEP NECK RD | | | | 10f. Zip Code
21662 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates 1960-62 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
EXECUTIVE | | | 16b. Kind of Business/Industry
ADVERTISING | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM WHITFIELD LEWIS, SR | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY CATHERINE ADAMS | | | |
| 19a. Informant's Name/Relationship (Type, Print)
DR. LEON LEWIS/BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
50 ROCKLEDGE RD. MONTVILLE, NJ 07045 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY SAVIOR CEMETERY | | Date
7-13-00 | | 20c. Location - City or Town, State
BETHLEHEM, PA | | | |
| 21. Signature of Funeral Service Licensee
<i>M. E. Munn</i> (CFSP) | | | | 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST. EASTON, MD 21601 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. HEPATIC FAILURE MASSIVE ASCITES
Due to (or as a consequence of):

b. ALCOHOL ABUSE HEPATIC FAILURE
Due to (or as a consequence of):

c. ALCOHOL ABUSE
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
2 MOS
2 MOS
UNKNOWN
2 YEARS | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
TOBACCO ABUSE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>M. E. Munn</i> | | | | 29c. License number
H42587 | | 29d. Date signed (Month, Day, Year)
7-10-00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RUSSELL E. SCHILLING M.D. 607 DUTCHMANS LANE EASTON, MD 21601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 11 2000 | | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Talbot

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 27306

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn Joan Long

2. Date of Death

Month Day Year
Aug 9 2000

3. Time of Death

11:50AM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

428 96 4801

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 11 1947

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2004 Amberleaf Place

10f. Zip Code

20602

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teachers aid

16b. Kind of Business/Industry

public school

17. Father's Name (First, Middle, Last)

James S. Long

18. Mother's Name (First, Middle, Maiden Summa)

Feriba Howard

19a. Informant's Name/Relationship (Type, Print)

Andrew Coon - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Aug 13 2000

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B Rausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. aortic valve rupture

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

b. subacute bacterial endocarditis

weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. C. Castrence MD

29c. License number

D-53592

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arnel C Castrence, MD Suite 100 12070 Old Line Center Waldorf MD 20602

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

A. C. Castrence

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27307

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JENNETTE ELIZABETH LAMOND

2. Date of Death

Month Day Year
August 9 2000

3. Time of Death

4:45 p.m.

4a. Facility Name (If not institution, give street and number)

395 Terrace Drive

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

215 26 3268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 26, 1932

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

395 Terrace Drive

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

data processor

16b. Kind of Business/Industry

University of MD

17. Father's Name (First, Middle, Last)

Raymond

Croson

18. Mother's Name (First, Middle, Maiden Summa)

Margaret

Jenkins

19a. Informant's Name/Relationship (Type, Print)

Douglas E. LaMond / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
So. Memorial Gardens

Date

8-14-00

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Endometrial Cancer

Approximate Interval Between Onset and Death

3 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

incarcerated incisional hernia with
gangrenous bowel

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce A. Silver, MD

29c. License number

D21463

29d. Date signed (Month, Day, Year)

8-11-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce A. Silver, MD 110 Hospital Rd Prince Frederick, MD 20678

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. A. Silver

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27308

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lou Murphy

2. Date of Death

Month Day Year

8 12 2000

3. Time of Death

1810

4a. Facility Name (If not institution, give street and number)

Heritage Harbor Health Rehab

4b. City, Town, or Location of Death

Annapolis md

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

085-22-2582

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12 18 26

9. Birthplace (State or Foreign Country)

Monroe New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2626 Point Lookout Cove

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Elmer Thaney

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Burke

19a. Informant's Name/Relationship (Type, Print)

Ralph F. Murphy, Jr. /Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2626 Point Lookout Cove Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

USNA Cemetery

Date

8/16/00

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

y/s

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Parkinsonism

Due to (or as a consequence of):

y/s

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Taylor MD

29c. License number

D41978

29d. Date signed (Month, Day, Year)

8-12-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nader Tavakoli

1 Hosp Dr Cheryl M.D 20785

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

G. Smith

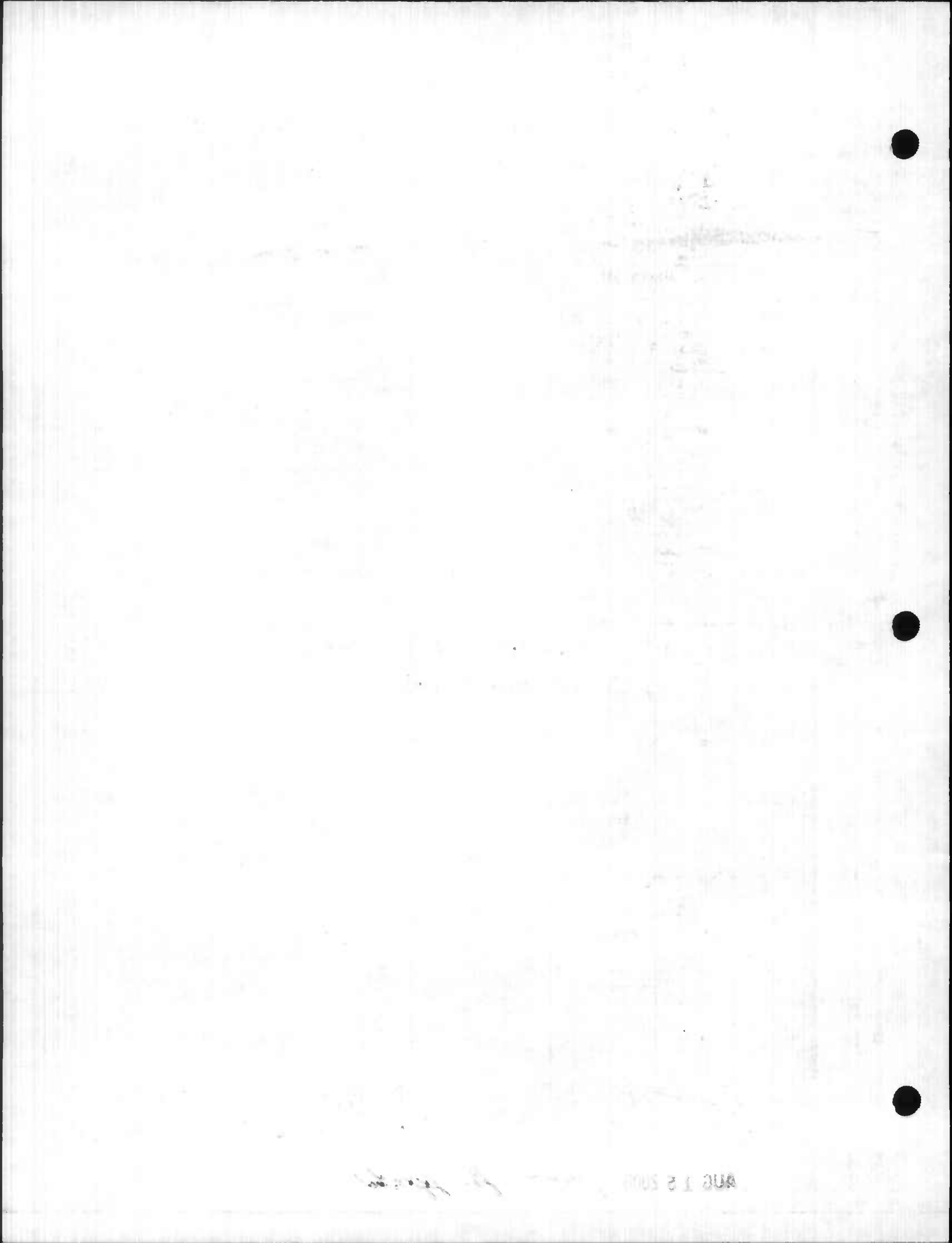
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27309

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|------------------------------------|--|--|---|---|--|---|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Michael John MANNING | | | | 2. Date of Death
Month Day Year
August 12 2000 | | 3. Time of Death
2230 | | | |
| | 4a. Facility Name (If not institution, give street and number)
957 Deer Creek Run | | | | 4b. City, Town, or Location of Death
Arnold | | 4c. County of Death
AA | | | |
| Funeral
Director | 5. Social Security Number
573-72-0874 | | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
52 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept 9, 1947 | 9. Birthplace (State or Foreign Country)
California | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Anne Arundel | | 10c. City, Town or Location
Arnold | | | 10d. Inside City Limits
1 Yes 2 No | | | |
| | 10e. Street and Number
957 Deer Creek Run | | | 10f. Zip Code
21012 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | | 16b. Kind of Business/Industry
Telecommunications | | | | |
| | 17. Father's Name (First, Middle, Last)
John Carlson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Campbell | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Janice Gabriel/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
957 Deer Creek Run, Arnold, MD 21012 | | | | | |
| | 20a. Method of Disposition
1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
Aug 15 2000 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>James E. Barranco</i> | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 21146 | | | | | |
| | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute Cardiac Arrhythmia
Due to (or as a consequence of):
Morbid Obesity
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Parkinson's Disease | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 <input checked="" type="checkbox"/> No 3 Probably 4 Unknown | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>William P. Jones</i> Deputy | | 29c. License number
D 06054 | | 29d. Date signed (Month, Day, Year)
8/13/00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William P. Jones, MD 695 America 21035 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
<i>James A. Jones</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten text at the top of the page, mostly illegible due to fading.

Second line of handwritten text, also illegible.

Third line of handwritten text, illegible.

Fourth line of handwritten text, illegible.

Fifth line of handwritten text, illegible.

Sixth line of handwritten text, illegible.

Seventh line of handwritten text, illegible.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27310

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret McElhearn

2. Date of Death

August 4 2000

3. Time of Death

9:00 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

122-24-1702

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Aug 16, 1932

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3395 Littleton Way

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles Kerr

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Butler

19a. Informant's Name/Relationship (Type, Print)

Thomas McElhearn/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3395 Littleton Way, Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

Aug 7 2000

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home

495 Gov. Ritchie Hwy Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hemo PERITONEUM 2° to liver biopsy

Due to (or as a consequence of):

b. HEPATOMA

Due to (or as a consequence of):

c. CIRRHOSIS OF LIVER 2° to

Due to (or as a consequence of):

d. HEPATITIS C

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Spinks MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

August 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela B. Spinks, 301 Hagerman Drive, Glen Burnie, MD, 21061.

State
Registrar

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

B. Spinks

ORIGINAL

MCELHEARN MARGARET

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27317

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine M. Morand

2. Date of Death
Month Day Year

August 2 2000

3. Time of Death

10:20 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

034-07-3926

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1907

9. Birthplace (State or Foreign Country)

Scotland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

112 Riggs Avenue

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Alexander Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Fettes

19a. Informant's Name/Relationship (Type, Print)

Frederick J. Morand/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Riggs Avenue Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Aug. 3 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy. Severna Park, MD 21146

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

UROSEPSIS

Due to (or as a consequence of):

ACUTE RENAL FAILURE

Due to (or as a consequence of):

HYPERNATREMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

MD

29c. License number

D45149

29d. Date signed (Month, Day, Year)

August 2 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OWABAYO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Morand, Catherine



Handwritten signature or scribble.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27312

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lloyd Douglas McDaniel | | | | 2. Date of Death
Month Day Year
August 6, 2000 | | 3. Time of Death
9:17 AM | |
| | 4a. Facility Name (If not institution, give street and number)
458 Nautical Ct. | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
244-82-1077 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
52 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jul 23, 1948 | 9. Birthplace (State or Foreign Country)
NC |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
458 Nautical Court | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Operation Manager | | | 16b. Kind of Business/Industry
Food Service & Vending | |
| 17. Father's Name (First, Middle, Last)
Loyd M. McDaniel | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Sechrest | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Maureen H. McDaniel/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
458 Nautical Court, Pasadena, MD 21122 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
Aug 10 2000 | | 20c. Location - City or Town, State
Baltimore, MD | | |
| 21. Signature of Funeral Service Licensee
<i>James E. Barranco</i> | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 21146 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
multiple system atrophy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
years | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Jeffrey Briggs MD</i> | | | | 29c. License number
D 28640 | | 29d. Date signed (Month, Day, Year)
August 6, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2414 Hightree Ct. Crofton Md 21114 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 08 2000 | | 32. Registrar's Signature
<i>James B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-5055.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


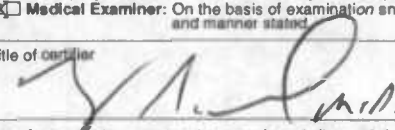

State of Maryland / Department of Health and Mental Hygiene

00 27313

Amended item#26perME 08/16/2000

Certificate of Death

FCHD,KS Reg. No.

| | | | | | |
|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth Ann Mitts | | 2. Date of Death
Month Day Year
AUGUST 10, 2000 | | 3. Time of Death
8:00 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
14043 EDMONT ROAD | | 4b. City, Town, or Location of Death
SMITHSBURG | | 4c. County of Death
WASHINGTON |
| Funeral
Director | 5. Social Security Number
220-54-4197 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth
Month Day Year
Dec. 5, 1950 | | 9. Birthplace (State or Foreign Country)
MD. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD. | | 10b. County
Washington | | 10c. City, Town or Location
Smithsburg | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number
14043 Edgemont Rd. | | | 10f. Zip Code
21783 | | 10g. Citizen of What Country?
U.S.A. |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | | 16b. Kind of Business/Industry
own home | |
| 17. Father's Name (First, Middle, Last)
Newton Love | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lois Wiles | | |
| 19a. Informant's Name/Relationship (Type, Print)
Earl B. Lucas (Friend) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14043 Edgemont Rd., Smithsburg, MD. 21783 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ceadr Lawn Memorial Park | | 20c. Location - City or Town, State
8/15 Hagerstown, MD. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | |
| Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 11, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPIK, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
 | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27314

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARVEY EDWARD MICHAEL

2. Date of Death

Month Day Year
AUGUST 11, 2000

3. Time of Death

8:45 PM

4a. Facility Name (If not institution, give street and number)

16210 OLD FREDERICK RD.

4b. City, Town, or Location of Death

EMMITSBURG

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

219-01-8862

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 16, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

FREDERICK

10c. City, Town or Location

EMMITSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16210 OLD FREDERICK RD.

10f. Zip Code

21727

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 41-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

GUARD

16b. Kind of Business/Industry

FORT DETRICK

17. Father's Name (First, Middle, Last)

SAMUEL EDWARD MICHAEL

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE RAPHAEL KOLB

19a. Informant's Name/Relationship (Type, Print)

THELMA MICHAEL/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16210 OLD FREDERICK RD., EMMITSBURG, MD. 21727

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. ANTHONY'S SHRINE CEM.

Date

8/16

20c. Location - City or Town, State

EMMITSBURG, MD.

21. Signature of Funeral Service Licensee

John M. Skiles

22. Name and Address of Facility

SKILES FUNERAL HOME

210 W. MAIN ST., EMMITSBURG, MD. 21727

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew J. Sanick

29c. License number

D35164

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW SANICK, JR., 1000 W. PATRICK ST. FREDERICK, MD 21703

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. B. B.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olis James Molock SR.

2. Date of Death

Month Day Year
08 12 2000

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

215-38-0665

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 1 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

910 Beaglin Park Drive

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Thomas Molock

18. Mother's Name (First, Middle, Maiden Surname)

Delancey Pinder

19a. Informant's Name/Relationship (Type, Print)

Ronald Molock (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9849 Wallertown Rd. Mardela, Md. 21837

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fork Neck Cemetery

Date

8/9/00

20c. Location - City or Town, State

Vienna, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Carcinoma of Pancreas*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Prostate
Insulin Dependent Diabetes Mellitus
Essential Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

8-14-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Geneva G. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27316

| | | | | | | | | |
|---|--|---|---|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES EDWARD MATTHEWS | | | | 2. Date of Death
Month 08 Day 11 Year 00 | | 3. Time of Death
2 AM | |
| | 4a. Facility Name (If not institution, give street and number)
DORCHESTER GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
CAMBRIDGE | | 4c. County of Death
DORCHESTER | |
| Funeral
Director | 5. Social Security Number
214-10-6129 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
101 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
December 25, 1898 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Dorchester | 10c. City, Town or Location
Cambridge | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
2339 Hudson Road | | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Meat Cutter | | | 16b. Kind of Business/Industry
Webb Packing Co. | | |
| | 17. Father's Name (First, Middle, Last)
Charles Edward Matthews | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Adams | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Bernice M. Kolas/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2339 Hudson Rd., Cambridge, MD 21613 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory Gardens | | Date
8/16/00 | | 20c. Location - City or Town, State
Hebron, MD | |
| | 21. Signature of Funeral Service Licensee
<i>David A. Thompson</i> | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Aspiration Pneumonia Due to (or as a consequence of): 2 wks
b. Cerebrovascular Accident Due to (or as a consequence of): 2 wks
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Reflux esophagitis
Degenerative arthritis | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>E. Tanman M.D.</i> | | 29c. License number
20014349 | | 29d. Date signed (Month, Day, Year)
8-11-00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eyup Tanman M.D. 15 Franklin St. Cambridge, MD 21613 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
<i>Benita B. Smith</i> | | | | | | |

ORIGINAL

2 From 11
G. m. 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27317

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEON MADDUX | | 2. Date of Death
Month Day Year
AUGUST 10, 2000 | | 3. Time of Death
9:58 PM |
| | 4a. Facility Name (If not institution, give street and number)
UNIVERSITY OF MARYLAND MEDICAL SYSTEM | | 4b. City, Town, or Location of Death
BALTIMORE, MD | | 4c. County of Death
BALTIMORE CITY |
| Funeral
Director | 5. Social Security Number
218-48-6963 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
51 Yrs. | 8. Date of Birth (Month, Day, Year)
5-29-49 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | |
| 10a. State
MD | | 10b. County
Wicomico | 10c. City, Town or Location
Quantico, MD 21856 | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
22134 Royal Oak Road | | 10f. Zip Code
21856 | | 10g. Citizen of What Country?
U.S.A | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | |
| 16b. Kind of Business/Industry
None | | 17. Father's Name (First, Middle, Last)
Leon George Maddox | | 18. Mother's Name (First, Middle, Maiden Surname)
Lelia Collins | |
| 19a. Informant's Name/Relationship (Type, Print)
Rebecca Maddox (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22134 Royal Oak Rd. Quantico, Md. 21856 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. James U.M. Church Cem. | | 20c. Location - City or Town, State
Westover, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
VENTRICULAR ARRHYTHMIA
Due to (or as a consequence of):
DILATED CARDIOMYOPATHY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CORONARY ARTERY DISEASE, DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE | | Approximate Interval Between Onset and Death
30 minutes
8 YEARS | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE, DIABETES MELLITUS, PERIPHERAL VASCULAR DISEASE | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
P13366 | |
| 29d. Date signed (Month, Day, Year)
August 10, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARVIN LAMAR BRYANT, JR., MD 22 SOUTH GREENE STREET, BALTIMORE, MD 20201 | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
 | | | |

ORIGINAL

4-10-1944

1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27318

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MADGE ELIZABETH MILLS

2. Date of Death

Month Day Year
AUG. 9, 2000

3. Time of Death

10:20 PM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, Md.

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

220-09-1773

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 19, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1415 Camden Ave

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4 or 5+)
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Corry Wallace

18. Mother's Name (First, Middle, Maiden Surname)

Annie White

19a. Informant's Name/Relationship (Type, Print)

A. Kenneth Mills/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 N. Camden Ave., Fruitland, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

8/12/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Many years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Airborne Bacteria Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, Md. 21804

State
Registrar

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director


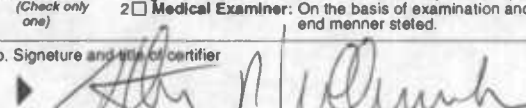
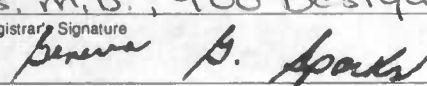
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27319

| | | | | | | | | |
|--|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT MARTIN MILBY | | | | 2. Date of Death
Month Day Year
August 07 2000 | | 3. Time of Death
12:15 pm | |
| | 4a. Facility Name (If not institution, give street and number)
5712 Nutwell-Sudley Road | | | | 4b. City, Town, or Location of Death
Deale | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
578-09-8232 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 3, 1923 | |
| | 9. Birthplace (State or Foreign Country)
Wash., D.C. | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Deale | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
5712 Nutwell-Sudley Road | | 10f. Zip Code
20751 | | |
| 10g. Citizen of What Country?
U.S.A. | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 44-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Budget Analyst | | 16b. Kind of Business/Industry
Federal Government | | |
| 17. Father's Name (First, Middle, Last)
Walter Milby | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown Hallett | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Barbara A. Milby / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5712 Nutwell-Sudley Rd., Deale, MD 20751 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodfield Cemetery | | 20c. Location - City or Town, State
8-10-00 Galesville, MD | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Rausch Funeral Home, P.A. Owings, MD 20736 | | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. CANCER PANCREAS | | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
8 mos | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D08118 | | |
| 29d. Date signed (Month, Day, Year)
8/8/2000 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stanley P. Watkins, M.D., 900 Bestgate Rd., Annapolis, MD 21401 | | 31. Date filed (Month, Day, Year)
AUG 10 2000 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15+1

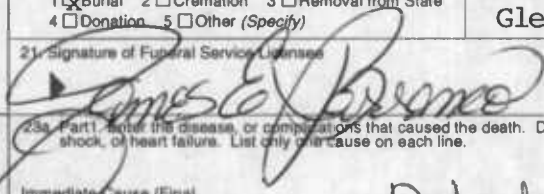
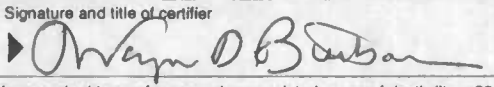
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27320

| | | | | | | | | |
|---|--|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret Lucille Nichols | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | 3. Time of Death
12:10am | |
| | 4a. Facility Name (If not institution, give street and number)
Country Home Harwood | | | | 4b. City, Town, or Location of Death
Harwood | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
213-34-5786 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | 8. Date of Birth (Month, Day, Year)
Dec 17, 1912 | 9. Birthplace (State or Foreign Country)
MD | | | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Harwood | |
| To Be Completed by
Funeral Director | 10e. Street and Number
4187 Solomons Island Road | | 10f. Zip Code
20776 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
State of Maryland | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Fleetwood | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Matthews | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carolyn Clark/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
510 Bay Green Drive, Arnold, MD 21012 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery | | Date
Aug 14 2000 | | 20c. Location - City or Town, State
Glen Burnie, MD | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 21146 | | | | | |
| | 23a. Part I. Note the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Dehydration
Due to (or as a consequence of):
b. Cancer of the Stomach
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
2 weeks
6 months | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | | | 29c. License number
D38563 | | 29d. Date signed (Month, Day, Year)
August 11, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wayne D. Breibbaum 134 Owensville Rd West River, MD | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

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0005 2 : 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27321

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
IRENE E. OWENS | | | | 2. Date of Death
Month Day Year
AUG. 9 2000 | | | | 3. Time of Death
2:25 am | | | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CLINTON | | | | 4c. County of Death
PRINCE GEORGES | | | |
| Funeral
Director | 5. Social Security Number
220-38-2910 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 22 1929 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| | 10a. State
MARYLAND | | | | 10b. County
ANNE ARUNDEL | | | | 10c. City, Town or Location
LOTHIAN | | | |
| To Be Completed by Funeral Director | 10e. Street and Number
1208 WHITTINGTON DRIVE | | | | 10f. Zip Code
20711 | | | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | | | 16b. Kind of Business/Industry
NONE | | | |
| | 17. Father's Name (First, Middle, Last)
JOHN COLE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EDDY DYSON | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
EDNA I. OWENS (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1208 WHITTINGTON DR. LOTHIAN, MD. 20711 | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOSES CEMETERY | | | | 20c. Location - City or Town, State
B/16/00 DRURY. MD. | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Larry B. Reese No 00483 | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Ventricular fibrillation
Due to (or as a consequence of):
b. Ventricular Tachycardia
Due to (or as a consequence of):
c. Coronary Atherosclerosis
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
5 mts.
approx. 10 mts.
More than 1 year | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus.
Congestive Heart failure | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | | |
| To Be Completed by Physician/Medical Examiner | | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Larry B. Reese | | | | 29c. License number
D50653 | | | |
| | | | | | 29d. Date signed (Month, Day, Year)
8-9-00 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GYAN C. SURANA
5851- Deale Churchton Rd. Deale MD. 20751 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 11 2000 | | | | 32. Registrar's Signature
B. [Signature] | | | | | | | |

0005 1 1 300A

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27322

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT BRUCE OGLE | | | | 2. Date of Death
Month August Day 11 , Year 2000 | | 3. Time of Death
11:32 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
13102-B, Old Frederick Road | | | | 4b. City, Town, or Location of Death
Rocky Ridge | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
214-10-4508 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 31, 1916 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Rocky Ridge | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
13102-B, Old Frederick Road | | 10f. Zip Code
21778 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dairy Farmer | | 16b. Kind of Business/Industry
Own Farm | | | | |
| 17. Father's Name (First, Middle, Last)
Harvey B. Ogle | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Grace Keilholtz | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Helen B. Ogle / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13102-B, Old Frederick Rd./ Rocky Ridge, MD 21778 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cemetery Mt. Tabor Lutheran Church | | 20c. Location - City or Town, State
Rocky Ridge, Maryland | | 20d. Date
8-16-00 | | |
| 21. Signature of Funeral Service Licensee
<i>Raymond Peterson</i> | | | | 22. Name and Address of Facility
Stauffer Funeral Home
1621 Opossumtown Pike/ Frederick, MD 21788 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. NON-SMALL CELL LUNG CANCER
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
4 YEARS | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HEMATURIA, CHRONIC ATRIAL FIBRILLATION, RADIATION TO PROSTATE | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Brian M. O'Connor, MD</i> | | 29c. License number
D31761 | | 29d. Date signed (Month, Day, Year)
8/14/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRIAN M. O'CONNOR MD 501 W. SEVENTH ST. FREDERICK, MD 21701 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
<i>B. Adams</i> | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27323

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH PRENDERGAST

2. Date of Death

AUGUST 13, 2000 8:15pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GIEN BURNIE

4c. County of Death

AA COUNTY

5. Social Security Number

244-42-8684

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jul 12, 1933

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

306 White Plains Court

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 54-6213. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Consumer Safety Officer

16b. Kind of Business/Industry

Bureau of Foods

17. Father's Name (First, Middle, Last)

Henry M. Prendergast

18. Mother's Name (First, Middle, Maiden Summa)

Ola Hayden

19a. Informant's Name/Relationship (Type, Print)

Kathryn Prendergast/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

306 White Plains Court, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial

Date

Aug 17
2000

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home

495 Gov. Ritchie Hwy Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Due to (or as a consequence of):

VENTRICULAR FIBRILLATION

b.

Due to (or as a consequence of):

MYOCARDIAL INFARCTION

c.

Due to (or as a consequence of):

HYPERTENSION ESSENTIAL

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MESENTERIC ARTERY INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

29c. License number

D 27157

29d. Date signed (Month, Day, Year)

AUGUST, 14 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYNOLD DEPESTRE

3100 TIMANUS LN #110 BALTIMORE, MD 21244

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. A. A. A.

ORIGINAL

PRENDERGAST, JOSEPH

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27324

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|--|---|--------------------------|---|---|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DONALD STANLEY PRYOR | | | | 2. Date of Death
Month Day Year
AUGUST 12 2000 | | | 3. Time of Death
1:26 p.m. | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
12416 Stottlemeyer Road | | | | 4b. City, Town, or Location of Death
Myersville | | | 4c. County of Death
Frederick | | | | | |
| Funeral
Director | 5. Social Security Number
217-28-5615 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
Mar 22 1932 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
Myersville | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 10a. State
Maryland | | 10b. County
Frederick | | 10e. Street and Number
12416 Stottlemeyer Road | | | | 10f. Zip Code
21773 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 52-60 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | | | 16b. Kind of Business/Industry
Snack Food Wholesaler | | | | | |
| 17. Father's Name (First, Middle, Last)
Roy William Pryor | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Inez Louise Reid | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Harriet Pryor/spouse | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12416 Stottlemeyer Road, Myersville, MD 21773 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark's Lutheran Cemt | | 20c. Date
8-15-00 | | 20d. Location - City or Town, State
Wolfsville, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Patty L. Furbush</i> | | | | 22. Name and Address of Facility
504 Main Street
Ricketts Funeral Home Myersville, MD 21773 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Cancer of gastro-esophageal junction</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29c. License number
D46473 | | 29d. Date signed (Month, Day, Year)
8/14/00 | |
| 29b. Signature and title of certifier
<i>Hind Hamdan MD</i> | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
<i>B. Spence</i> | | | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

00 27325

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARGARET ELEANOR PHILLIPS | | | | 2. Date of Death
Month AUGUST Day 12 Year 2000 | | | | 3. Time of Death
11:27a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
077-34-1164 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth
Month Nov. Day 25 Year 1938 | | 9. Birthplace (State or Foreign Country)
N. Y. | |
| | Usual Residence of Decedent | | | | 10a. State
MD. | | 10b. County
Frederick | | 10c. City, Town or Location
Middletown | |
| To Be Completed by Funeral Director | 10e. Street and Number
7808 Grandview Place | | | | 10f. Zip Code
21769 | | | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4or 5+) | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
registered nurse | | | | 16b. Kind of Business/Industry
hospital | |
| | 17. Father's Name (First, Middle, Last)
Walter Ryan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret O'Hara | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Donald E. Phillips (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7808 Grandview Place, Middletown, MD. 21769 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Reformed Cemetery | | | | 20c. Location - City or Town, State
8/17 Middletown, MD. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. hepatic failure
Due to (or as a consequence of):

b. metastatic tumor
Due to (or as a consequence of):

c. B-cast cancer
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death

10 d

1 yr

14 yrs | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
B-cast metastasis | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year)
8/15/98 | | | | 28b. Time of Injury
M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
014025 | |
| | 29d. Date signed (Month, Day, Year)
Aug 12, 2000 | | | | 29e. Date of Death (Month, Day, Year)
Aug 12, 2000 | | | | 29f. Time of Death
11:27a.m. | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D. G. Thompson 501 W 7th St Frederick MD | | | | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
 | |
| | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27326

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
June E. Poole | | | | 2. Date of Death
Month August Day 15, Year 2000 | | 3. Time of Death
10:20 AM | |
| | 4e. Facility Name (If not institution, give street and number)
St. Catherines Nursing Center | | | | 4b. City, Town, or Location of Death
Emmitsburg | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
216-14-6780 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 22, 1921 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Thurmont | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number
20 West Moser Road | | | 10f. Zip Code
21788 | | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) - | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | |
| 16b. Kind of Business/Industry
Textile | | | 17. Father's Name (First, Middle, Last)
Howard Martin Baltzell | | | 18. Mother's Name (First, Middle, Maiden Surname)
Norma Cecilia Shipley | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gerald L. Baltzell / son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
621 Range End Road, Dillsburg, PA 17019 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven Memorial Gardens | | | 20c. Location - City or Town, State
Frederick, Maryland | | |
| 21. Signature of Funeral Service Licensee
P.B. Mack | | | 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
104 E. Main Street, Thurmont, Maryland 21788 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. HEPATIC ENCEPHALOPATHY
Due to (or as a consequence of):
b. CIRRHOSIS OF LIVER
Due to (or as a consequence of):
c. HEPATITIS C
Due to (or as a consequence of):
d. {
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how Injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
W. Fakhar | | | 29c. License number
D0054580 | | | 29d. Date signed (Month, Day, Year)
Aug 16, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wasim Fakhar, MD 49 Frederick Street, Taneytown, Maryland 21787 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 18 2000 | | | 32. Registrar's Signature
B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27327

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RACHAEL ANNE PARSONS | | 2. Date of Death
Month Day Year
AUGUST 9, 2000 | | 3. Time of Death
20:44 |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital | | 4b. City, Town, or Location of Death
Prince Fredrick Calvert | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
220-32-1142 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F
X | 7. Age (In yrs. last birthday)
66 Yrs. | 8. Date of Birth (Month, Day, Year)
12-20-1933 | 9. Birthplace (State or Foreign Country)
Md. |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Wicomico | 10c. City, Town or Location
Salisbury | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
6140 Florence St. | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker | | 16b. Kind of Business/Industry
Owned Home | | |
| | 17. Father's Name (First, Middle, Last)
John Edgar Robinson | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertie Harrington | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Howard Parsons Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6140 Florence St. Salisbury, Md. 21804 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Turners Cemetery | | 20c. Location - City or Town, State
8-14-00 Nanticoke, Md. |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
 Moo416 | | 22. Name and Address of Facility
Messick Funeral Home P.O. Box 61 Bivalve, Md. 21814 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. Anoxic Brain Encephelopathy 5 days
Due to (or as a consequence of):</p> <p>b. Severe Chronic Obstructive Pulmonary disease
Due to (or as a consequence of):</p> <p>c. Non insulin dependent Diabetes Mellitus
Due to (or as a consequence of):</p> <p>d. Steroid dependent Asthma</p> </div> </div> | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| State
Registrar | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was cause referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | |
| | 28b. Time of Injury
1 Yes 2 <input type="checkbox"/> No | | 28c. Describe how injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D45092 | | 29d. Date signed (Month, Day, Year)
8/10/00 |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. PARUL JANI, MD., PRINCE FREDERICK, MARYLAND 20678 (110 Hospital Rd #303) | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 27328

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIS H. ROGERS JR. | | | | 2. Date of Death
Month Day Year
AUGUST 7 2000 | | 3. Time of Death
5:55 PM | |
| | 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 4b. City, Town, or Location of Death
LANHAM | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
587-30-8079 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAY 14 1951 | 9. Birthplace (State or Foreign Country)
MISSISSIPPI | |
| | Usual Residence of Decedent
10a. State
MARYLAND | | | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
LANHAM | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
10124 ELLARD DRIVE | | 10f. Zip Code
20706 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 yrs. | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SYSTEMS ENGINEER 2 | | | | 16b. Kind of Business/Industry
BELL ATLANTIC | | | |
| | 17. Father's Name (First, Middle, Last)
WILLIS H. ROGERS SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
CORA HOWARD | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ANGEL BARNARD-ROGERS (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10124 ELLARD DR. LANHAM, MD. 20706 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | 20c. Location - City or Town, State
8/10/00 BALTIMORE, MD. | |
| | 21. Signature of Funeral Service Licensee
Harry D. Reese M004182 | | | | 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
c. PULMONARY EMBOLUS
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETIC GASTROPARESIS | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Dr. Subhan Mathew M.D. | | | | |
| 29c. License number
D 47604 | | | | 29d. Date signed (Month, Day, Year)
AUGUST 8, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SUBHAN MATHEW 2905 MITCHEWILLE RD 104 BOWIE MD 20716 | | | | 31. Date filed (Month, Day, Year)
AUG 11 2000 | | | | |
| 32. Registrar's Signature
B. Jones | | | | 33. State Registrar | | | | |

ORIGINAL

Aug 11 5000

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27329

| | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret V. Rieck | | | | 2. Date of Death
Month August Day 10 Year 2000 | | | | 3. Time of Death
2:45 | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
212-10-5441 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 7, 1909 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | 10a. State
DE | | | | 10b. County
Sussex | | 10c. City, Town or Location
Delmar | | | |
| To Be Completed by Funeral Director | 10e. Street and Number
101 E. Delaware Avenue | | | | 10f. Zip Code
19940 | | | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesperson | | | | 16b. Kind of Business/Industry
Gift Shop | |
| | 17. Father's Name (First, Middle, Last)
Charles E. Briley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hannah Eisinger Briley | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Elizabeth M. Ringrose/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Danny's Drive Laurel, DE 19956 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Park | | | | 20c. Location - City or Town, State
Elkridge, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Short Funeral Home
700 West Street Laurel, DE 19956 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia
Due to (or as a consequence of):

b. ASCD
Due to (or as a consequence of):

c. dementia
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
 | | | | 28b. Time of Injury
M | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred
 | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
 | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
 | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
NATAN MD | | | | 29c. License number
847094 | |
| | 29d. Date signed (Month, Day, Year)
8/12/00 | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NATESAN 106 MILFORD STREET SALISBURY MD 21804 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27330

| | | | | | | | | |
|---|--|--|---|--|--|--|---------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN STUART RING JR | | | | 2. Date of Death
Month Day Year
August 6, 2000 | | 3. Time of Death
8:30 PM | |
| | 4a. Facility Name (If not institution, give street and number)
10180 Adams Street | | | | 4b. City, Town, or Location of Death
Salisbury | | 4c. County of Death
Wicomico | |
| Funeral
Director | 5. Social Security Number
024-16-6682 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 7, 1923 | | 9. Birthplace (State or Foreign Country)
New York |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
10180 Adams Street | | | | 10f. Zip Code
21804 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Navy
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Contract Administrator | | 16b. Kind of Business/Industry
Dept. of Defense | | |
| 17. Father's Name (First, Middle, Last)
John Stuart Ring Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Abely | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Danielle Ring/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1120 19th St., NW, Washington, DC 20036 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary Cemetery | | 20c. Location - City or Town, State
8/15/00 Boston, MA | | |
| 21. Signature of Funeral Service Licensee
Kell R. Harvey | | | | 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Anterior clexotic Heart Disease
Due to (or as a consequence of):
b. Anterior clexani
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus, type I,
Diabetic polyneuropathy,
Status post Aortic Valve replacement | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number
D37670 | | 29d. Date signed (Month, Day, Year)
8/7/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. L.H. Evangelista | | | | 104 Pine Bluff Rd #4
Salisbury, MD 21801 | | | | |
| 31. Date filed (Month, Day, Year)
AUG 10 2000 | | | | 32. Registrar's Signature
Gene B. Sparks | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27331

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Herbert William Reuszer | | | | 2. Date of Death
Month August Day 13 Year 2000 | | 3. Time of Death
1742 | |
| | 4a. Facility Name (If not institution, give street and number)
The Memorial Hospital | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
315-38-7396 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
97 Yrs. | | 8. Date of Birth (Month, Day, Year)
August 4, 1903 | |
| | 9. Birthplace (State or Foreign Country)
Missouri | | 10a. State
Maryland | | 10b. County
Caroline | | 10c. City, Town or Location
Denton | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
10161 River Landing Road | | | |
| | 10f. Zip Code
21629 | | | | 10g. Citizen of What Country?
United States | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Caucasian | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Professor | | 16b. Kind of Business/Industry
Agronomy | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
John R. Reuszer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma E. Kuhn | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret Myers Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10161 River Landing Road, Denton, Maryland 21629 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grand View Cemetery | | Date
8/23/00 | | 20c. Location - City or Town, State
West Lafayette, Indiana | |
| | 21. Signature of Funeral Service Licensee
<i>Randolph P. Moore</i> | | 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

several days | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
malnutrition | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Karen Moffett</i> | | | | 29c. License number
D51639 | | 29d. Date signed (Month, Day, Year)
8-13-00 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karen Moffett, M.D., PO Box 660, Denton, Maryland 21629 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
<i>B. Jones</i> | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27332

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|---|----|--------------|--------|----|--------------------------|---------|----|-------------------------|-------|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marjorie Knopp REVELL | | | | | 2. Date of Death
Month Day Year
August 5, 2000 | | 3. Time of Death
3:30 p.m. | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
612 Clark Avenue | | | | | 4b. City, Town, or Location of Death
Deale | | 4c. County of Death
Anne Arundel | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217 62 8843 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
92 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 22, 1907 | | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Deale | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 10e. Street and Number
612 Clark Avenue | | | | 10f. Zip Code
20751 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6
College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
housewife | | | 16b. Kind of Business/Industry
own home | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
George Knopp | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ellen Collins | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Doris Knopp (sister-in-law) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as 10 above | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Mem. Cemetery | | Date
8-8-00 | | 20c. Location - City or Town, State
Annapolis, MD | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Rausch Funeral Home, Owings, MD 20736 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>hyponatremia</td> <td>8 days</td> </tr> <tr> <td>b.</td> <td>congestive heart failure</td> <td>6 weeks</td> </tr> <tr> <td>c.</td> <td>coronary artery disease</td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | hyponatremia | 8 days | b. | congestive heart failure | 6 weeks | c. | coronary artery disease | years | d. | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | hyponatremia | 8 days | | | | | | | | | | | | | | | | | | |
| | b. | congestive heart failure | 6 weeks | | | | | | | | | | | | | | | | | | |
| | c. | coronary artery disease | years | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Biliary colic | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Kari A. Bichell MD | | | | | 29c. License number
D37291 | | 29d. Date signed (Month, Day, Year)
8/7/00 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kari A. Bichell MD 134 Owensville Rd, West River MD 20778 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 10 2000 | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | |

1. The first part of the report
describes the general situation
of the country in 1945.

2. The second part of the report
describes the situation in 1946.

3. The third part of the report
describes the situation in 1947.
The fourth part of the report
describes the situation in 1948.
The fifth part of the report
describes the situation in 1949.

Amended # 7, nla,
8/18/20, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27333

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN MORELAND RILEY | | | | 2. Date of Death
Month Day Year
AUGUST 14, 2000 | | 3. Time of Death
02:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
232-78-1767 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 66 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 7, 1934 | |
| | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | 10a. State
WV | | 10b. County
HAMPSHIRE | | 10c. City, Town or Location
AUGUSTA | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
HC 71, BOX 12-F | | 10f. Zip Code
26704 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER'S AIDE | | 16b. Kind of Business/Industry
EDUCATION | | | | |
| 17. Father's Name (First, Middle, Last)
GARLAND MORELAND | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LULA MILLESON | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PAUL E. RILEY / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HC 71, BOX 12-F, AUGUSTA, WV 26704 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOODROW CEMETERY | | Date
8/17/00 | | 20c. Location - City or Town, State
PAW PAW, WV | | |
| 21. Signature of Funeral Service Licensee
<i>Ray J. Giffin</i> | | | | 22. Name and Address of Facility
GIFFIN FUNERAL HOME, INC.
P.O. BOX 100, CAPON BRIDGE, WV 26711 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Endstage Metastatic Adenocarcinoma of Colon</i>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | Approximate Interval Between Onset and Death
3 mo | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Gary Wagoner</i> | | 29c. License number
D22181 | | 29d. Date signed (Month, Day, Year)
AUGUST 15, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Gary Wagoner, M.D. 925 Bishop Walsh Rd. Cumberland MD 21502</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
<i>Anna B. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-638-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature or initials

0005 8 1 00A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27334

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Carol Richter</u> | | 2. Date of Death
Month <u>August</u> Day <u>9</u> Year <u>2000</u> | | 3. Time of Death
<u>0855</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>Johns Hopkins Hospital</u> | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
<u>220-54-2159</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>53</u> Yrs. | 8. Date of Birth (Month, Day, Year)
<u>April 1, 1947</u> | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>MD</u> | 10b. County
<u>Queen Anne's</u> | 10c. City, Town or Location
<u>Stevensville</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
<u>119 Indian Plantation Dr.</u> | | 10f. Zip Code
<u>21666</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>2</u> | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Consultant</u> | | 16b. Kind of Business/Industry
<u>Medical</u> | | |
| | 17. Father's Name (First, Middle, Last)
<u>Joseph Quinn</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Nancy Cook</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Brian Richter/ Husband</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>119 Indian Plantation Dr. Stevensville MD 21666</u> | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Chesapeake Cremation Center</u> | | 20c. Location - City or Town, State
<u>Stevensville, MD</u> |
| | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | 22. Name and Address of Facility
<u>Fellows, Helfenbein & Newnam Funeral Home P.A.
106 Shamrock Rd, Chester MD 21619</u> | | |
| | 23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death)
a. <u>Pulmonary hypertension</u>
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
<u>2 years</u> |
| | b. <u>Scleroderma</u>
Due to (or as a consequence of): | | | | <u>10 years</u> |
| | c. _____
Due to (or as a consequence of): | | | | |
| | d. _____
Due to (or as a consequence of): | | | | |
| To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
<u>M</u> | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
<u>G.K. Bruce MD</u> | | 29c. License number
<u>RES-000</u> | | 29d. Date signed (Month, Day, Year)
<u>August 8, 2000</u> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>G.K. Bruce MD Tower 110, 600 N. Wolfe Street, Baltimore MD 21287</u> | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<u>AUG 11 2000</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27335

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Donald M. Scott | | | | 2. Date of Death
Day: Aug. 4, Year: 2000 | | 3. Time of Death
1:38 am | | | |
| | 4a. Facility Name (If not institution, give street and number)
Hospice of Baltimore - Gilchrist Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | |
| Funeral
Director | 5. Social Security Number
121-24-0139 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | If Under 1 Year
Months: Days: | If Under 24 Hrs.
Hours: Min. | 8. Date of Birth (Month, Day, Year)
Nov. 17, 1929 | | 9. Birthplace (State or Foreign Country)
New Jersey | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Anne Arundel | 10c. City, Town or Location
Severna Park | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
700 Laurel Lane | | | 10f. Zip Code
21146 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1952 - 1954 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Senior Technical Consultant | | | 16b. Kind of Business/Industry
Electrical Engineering | | | |
| | 17. Father's Name (First, Middle, Last)
Norman D. Scott | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Jobse | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary Lou Scott/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
700 Laurel Lane, Severna Park, MD 21146 | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Cemetery | | Date
Aug 11 2000 | | 20c. Location - City or Town, State
Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>James E. Barranco</i> | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 21146 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>prostate cancer</u>
Due to (or as a consequence of):
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
years | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Anthony Riley</i> | | | | 29c. License number
D25205 | | 29d. Date signed (Month, Day, Year)
August 4, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204 | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 08 2000 | | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

ORIGINAL

AUGUST 4, 2000 @ 1:38 AM
Baltimore, Maryland 21215-0020SCOTT, DONALD
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

ENCLOSURE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27336

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MERHL WILLIAM SULCER, SR. | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | 3. Time of Death
9:20 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death
Frederick | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
220-05-6718 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct 27, 1921 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Frederick | | 10c. City, Town or Location
Frederick | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
602 Culler Avenue | | 10f. Zip Code
21701 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No World War II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner/Operator | | 16b. Kind of Business/Industry
Restaurant | | | |
| | 17. Father's Name (First, Middle, Last)
Alvie Newton Sulcer | | 18. Mother's Name (First, Middle, Maiden Surname)
Hester Manzella Snoots | | 19a. Informant's Name/Relationship (Type, Print)
Mrs Betty L. Sulcer/Wife | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
602 Culler Avenue, Frederick, Maryland 21701 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery Aug 14, 2000 | | 20c. Location - City or Town, State
Frederick, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>Karl Lynn Robinson</i> M00706 | | 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 21701 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Respiratory failure / CHF
Due to (or as a consequence of):
ESRD
Due to (or as a consequence of):
CAD
Due to (or as a consequence of):
COPD | | | | | | Approximate Interval Between Onset and Death
1-2 days
2 weeks
10 years
5 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
fluid overload. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Nancy S. Thompson M.D.</i> | | 29c. License number
D55995 | | 29d. Date signed (Month, Day, Year)
08/12/2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nancy S. Thompson, M.D., 172 Thomas Johnson Dr, Suite 202, Frederick, MD 21702 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
<i>B. Spaul</i> | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 27337

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--------------------------------|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Henry Stevenson | | | | 2. Date of Death
Month Day Year
August 11 2000 | | 3. Time of Death
10-48 | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
218-24-7476 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 24 1929 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Wicomico | | 10c. City, Town or Location
Salisbury | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
717 Wilson Lane | | | | 10f. Zip Code
21801 | | 10g. Citizen of What Country?
U.S.A | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea War | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Laborer | | 16b. Kind of Business/Industry
None | | | | |
| | 17. Father's Name (First, Middle, Last)
Nathaniel Stevenson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Georgia Custis | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Christopher H. Stevenson (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
717 Wilson Lane Salisbury, Md. 21801 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Vet. Cem. Eastern Shore | | 20c. Location - City or Town, State
Hurlock, Md. | | 20d. Date
8/18/00 | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ALCOHOLIC CARDIOMYOPATHY
Due to (or as a consequence of):
c. ALCOHOLISM
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
1 HOUR
1 YEAR
20 YEARS | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 46962 | | 29d. Date signed (Month, Day, Year)
August 12, 2000. | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CTR. MD 21081 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27338

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|-------------------------|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EMMA M. SMULLEN | | | | 2. Date of Death
Month Day Year
August 8 2000 | | | | 3. Time of Death
1520 | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
219-36-6433 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
APRIL 4, 1909 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
WICOMICO | | 10c. City, Town or Location
SALISBURY | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
501 PINE BLUFF RD | | | | 10f. Zip Code
21801 | | | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TEACHER | | | | 16b. Kind of Business/Industry
PUBLIC SCHOOL | | |
| 17. Father's Name (First, Middle, Last)
HENRY MARKS | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
STEPHEN W. SMULLEN - grandson | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3140 GARDEN BAR LINCOLN, CA 95648 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARSONS CEMETERY | | Date
8/12/00 | | 20c. Location - City or Town, State
SALISBURY, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
705 E. MAIN ST.
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 | | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Renal Failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
D 30743 | | | 29d. Date signed (Month, Day, Year)
August 10, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BENJAMIN MEYER, M.D. 400 EASTERN SHORE DR. SALISBURY, MD 21804 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 11 2000 | | | | | 32. Registrar's Signature
 | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

219-36-6433
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Emma Smullen
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

00 27339

Certificate of Death

Reg. No.

| | | | | | | |
|---|---|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY Elizabeth ST. PIERRE | | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
06:50 |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital | | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert Co. |
| Funeral
Director | 5. Social Security Number
016-18-3991 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 | If Under 1 Year
Months Days | 8. Date of Birth (Month, Day, Year)
Nov. 10, 1920 | 9. Birthplace (State or Foreign Country)
Massachusetts |
| | Usual Residence of Decedent | | | | | |
| To Be Completed by Funeral Director | 10a. State
MA | 10b. County
Plymouth Co. | 10c. City, Town or Location
Bridgewater | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
57 Stetson Street | | 10f. Zip Code
02324 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | |
| | 16b. Kind of Business/Industry
Home | | 17. Father's Name (First, Middle, Last)
Edward F. Wise | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary E. McGovern | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Robert R. St. Pierre (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3541 Deep Landing Road Huntingtown, MD 20639 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Thomas of Aquinas Ch. Cemetery | | 20c. Location - City or Town, State
Aug. 17, 2000 Bridgewater, MA | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility
Lee Funeral Home Calvert, P.A.
8125 Southern Maryland Blvd. Owings, MD 20736 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute Renal Failure | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier | | 29c. License number
DS1949 | | 29d. Date signed (Month, Day, Year)
8/13/00 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DAVID GALLATIN PRINCE FREDERICK, MD 20678 | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
B. Spahr | | | |

2. 1. 1900

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27340

| | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|--|--|---|--|--|-------------------------------------|--|---|--|--|-----------------------------------|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARILYN ELAINE SIPE | | 2. Date of Death
Month Day Year
AUGUST 12, 2000 | | 3. Time of Death
18:03 | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219 42 4832 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
55 Yrs. | 8. Date of Birth (Month, Day, Year)
June 16, 1945 | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Calvert | 10c. City, Town or Location
Huntingtown | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number
3712 Hunting Creek Road | | 10f. Zip Code
20639 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | | |
| | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) | | | | | | | | | | | | | | | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
housewife | | 16b. Kind of Business/Industry
own home | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
William Pyles Fink | | 18. Mother's Name (First, Middle, Maiden Surname)
Lena Bland Clark | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
William N. Sipe (husb.) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as 10 above | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Miranda Cemetery | | 20c. Location - City or Town, State
8-16-00 Huntingtown, MD | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Rausch Funeral Home, Owings, MD 20736 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial Infarction</td> <td rowspan="4">Approximate Interval Between Onset and Death
15 minutes</td> </tr> <tr> <td>b. Due to (or as a consequence of):
Coronary Artery Disease</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | Approximate Interval Between Onset and Death
15 minutes | b. Due to (or as a consequence of):
Coronary Artery Disease | c. Due to (or as a consequence of): | d. Due to (or as a consequence of): | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | Approximate Interval Between Onset and Death
15 minutes | | | | | | | | | | | | | | | | | |
| | b. Due to (or as a consequence of):
Coronary Artery Disease | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table> | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="4">26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td>27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td>28a. Date of Injury (Month, Day Year)</td> <td>28b. Time of Injury
M</td> <td>28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td>28d. Describe how injury occurred</td> </tr> <tr> <td colspan="3">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> | | | | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner</td> <td colspan="4">29b. Signature and title of certifier
</td> </tr> <tr> <td colspan="2">29c. License number
DS1949</td> <td colspan="3">29d. Date signed (Month, Day, Year)
8/13/00</td> </tr> </table> | | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner | 29b. Signature and title of certifier
 | | | | 29c. License number
DS1949 | | 29d. Date signed (Month, Day, Year)
8/13/00 | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Medical Examiner | 29b. Signature and title of certifier
 | | | | | | | | | | | | | | | | | | |
| 29c. License number
DS1949 | | 29d. Date signed (Month, Day, Year)
8/13/00 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DAVID GALLATIN PRINCE FREDERICK, MD 20678 | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>31. Date filed (Month, Day, Year)
AUG 16 2000</td> <td colspan="4">32. Registrar's Signature
</td> </tr> </table> | | | | | 31. Date filed (Month, Day, Year)
AUG 16 2000 | 32. Registrar's Signature
 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27341

| | | | | | |
|---|--|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE SCHWARTZ, JR. | | 2. Date of Death
Month August Day 18 Year 2000 | | 3. Time of Death
APPROX 1100P |
| | 4e. Facility Name (If not institution, give street and number)
27831 Bullock Road | | 4b. City, Town, or Location of Death
Federalsburg | | 4c. County of Death
Caroline |
| Funeral
Director | 5. Social Security Number
271-20-7701 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | 8. Date of Birth (Month, Day, Year)
Aug. 18, 1925 | 9. Birthplace (State or Foreign Country)
Ohio |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Caroline | 10c. City, Town or Location
Federalsburg | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
27831 Bullock Road | | 10f. Zip Code
21632 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (14 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Architect |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
George Schwartz, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Bene | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Marlene B. Schwartz/Spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27831 Bullock Rd., Federalsburg, MD 21632 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cambridge Crematory | | 20c. Location - City or Town, State
Cambridge, Maryland |
| | 21. Signature of Funeral Service Licensee
Michael F. Gibson | | 22. Name and Address of Facility
Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. DIABETES MELLITUS
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
10 YEARS |
| | b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year)
N/A | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred
N/A | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A | | | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and Title of certifier
C. Jensen MD | | | | | |
| 29c. License number
D14664 | | | | | |
| 29d. Date signed (Month, Day, Year)
08/19/00 | | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
CHRISTIAN E. JENSEN MD / P.O. Box 690, DENTON MD 21629 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 22 2000 | | | | | |
| 32. Registrar's Signature
Beverly B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27342

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LOUISE ANN THOMPSON SWANN | | | | 2. Date of Death
Month: AUGUST Day: 15, Year: 2000 | | 3. Time of Death
5:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
RESIDENCE. 4385 SWANN'S DRIVE | | | | 4b. City, Town, or Location of Death
WHITE PLAINS | | 4c. County of Death
CHARLES | |
| Funeral
Director | 5. Social Security Number
217-32-1685 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
MARCH 28, 1930 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
CHARLES | | 10c. City, Town or Location
WHITE PLAINS / LA PLATA | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
4385 SWANN'S DRIVE / P.O. BOX 312 | | 10f. Zip Code
20646 | | 10g. Citizen of What Country?
UNITED STATES | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | 16b. Kind of Business/Industry
HOMEMAKER | | | | |
| 17. Father's Name (First, Middle, Last)
LEE THOMPSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BEENA SWANN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOSEPH L. SWANN / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 312 LA PLATA, MARYLAND 20646 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. JOSEPH'S CHURCH CEM. | | 20c. Location - City or Town, State
POMFRET, MARYLAND | | 20d. Date
8/18/00 | | |
| 21. Signature of Funeral Service Licensee
<i>Lydia C. Thornton Johnson</i>
LYDIA C. THORNTON JOHNSON M00583 | | 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <i>chronic obstructive airway (pulmonary) disease (Bronchial Asthma)</i>
Due to (or as a consequence of):</p> <p>b. _____
Due to (or as a consequence of):</p> <p>c. _____
Due to (or as a consequence of):</p> <p>d. _____
Due to (or as a consequence of):</p> </div> </div> | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Yahia M. Tagouni MD</i> | | 29c. License number
D0050883 | | 29d. Date signed (Month, Day, Year)
8-15-00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>YAHIA M. TAGOUNI 11655 Winesap Pl La Plata MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
<i>Beverly G. Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27343

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES GANTT STEVENS

2. Date of Death

Month 11, Day 2000 Year

3. Time of Death

2:35 A.M.

4a. Facility Name (If not institution, give street and number)

773 GARLETT'S ROAD

4b. City, Town, or Location of Death

FRIENDSVILLE

4c. County of Death

GARRETT CO.

Funeral
Director

5. Social Security Number

578-07-2920

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 11, Day 16, Year 12

9. Birthplace (State or Foreign Country)

MAYO, MD

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT CO.

10c. City, Town or Location

FRIENDSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

773 GARLETT'S ROAD

10f. Zip Code

21531

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MASTER AUTO MECHANIC

16b. Kind of Business/Industry

AUTO REPAIR

17. Father's Name (First, Middle, Last)

THOMAS EDDY STEVENS

18. Mother's Name (First, Middle, Maiden Surname)

IDA MAE BAYLISS

19a. Informant's Name/Relationship (Type, Print)

JANNIE F. STEVENS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

773 GARLETT'S ROAD FRIENDSVILLE MD 21531

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BIG CROSSING CEMETERY

Date

8-14-00

20c. Location - City or Town, State

FRAZEE RIDGE ROAD FRIENDSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ADENO CARCINOMA OF COLON

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D15333

29d. Date signed (Month, Day, Year)

8/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS G. JOHNSON, M.D., 311 N 4TH ST., OAKLAND, MD 21550

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

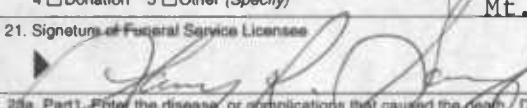
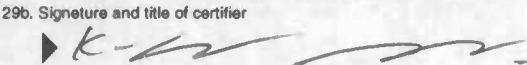
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27344

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Christine Thompson | | | | 2. Date of Death
Month August Day 16 , Year 2000 | | 3. Time of Death
4:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
4103 Erv Court | | | | 4b. City, Town, or Location of Death
Jefferson | | 4c. County of Death
Frederick | |
| Funeral
Director | 5. Social Security Number
212-50-7615 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
53 Yrs. | | 8. Date of Birth (Month, Day, Year)
5-13-1947 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
MD | | 10b. County
Frederick | | 10c. City, Town or Location
Jefferson | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4103 Erv Court | | 10f. Zip Code
21755 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
School Teacher | | 16b. Kind of Business/Industry
Education | | | |
| | 17. Father's Name (First, Middle, Last)
James Bosler | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Hall Bosler | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
John C. Thompson/ husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4103 Erv Court Jefferson MD 21755 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery | | 20c. Date
8-19-2000 | | 20d. Location - City or Town, State
Frederick, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
1621 Opossumtown Pike Frederick, Maryland 21702 | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Malignant Brain Tumor | | Approximate Interval Between Onset and Death
1 year | | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)
Malignant Brain Tumor | | Due to (or as a consequence of): | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Malignant Brain Tumor | | Due to (or as a consequence of): | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D41866 | | 29d. Date signed (Month, Day, Year)
August 17, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KANAN HUDRUD, MD
801 Tollhouse Avenue, F, FREDERICK, MARYLAND 21701 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
 | | | | | |
| | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27345

| | | | | | | | | | |
|--|---|---|--|--|---|--|---------------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORIS MAE THORNE | | | | 2. Date of Death
Month Day Year
August 15 2000 | | 3. Time of Death
6:46 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Civista Medical Center | | | | 4b. City, Town, or Location of Death
LaPlata | | 4c. County of Death
Charles | | |
| Funeral
Director | 5. Social Security Number
577-32-9797 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
73 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
January 10, 1927 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
Prince Georges | | 10c. City, Town or Location
Oxon Hill | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
1112 Elkhart Street | | | | 10f. Zip Code
20745 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accounts Payable Clerk | | 16b. Kind of Business/Industry
Justice Dept. Federal Govt. | | | |
| 17. Father's Name (First, Middle, Last)
John William Cusic | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Mae Buckler Cusic | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Donna Moy/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7853 Wicker Lane La Plata, MD 20646 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. | | 20c. Date
8/18/00 | | 20d. Location - City or Town, State
Cheltenham, MD | | | |
| 21. Signature of Funeral Service Licensee
David C. Ehrlich M00945 | | | | 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A.
P.O. BOX 567 LA PLATA, MD. 20646 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Robert T. Pace, M.D. | | | | 29c. License number
D-22574 | | 29d. Date signed (Month, Day, Year)
8/16/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert T. Pace, M.D., | | | | 12070 Old Line Center Suite 202
Waldorf, Maryland 20602 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27346

Certificate of Death

Reg. No.

| | | | | | | |
|--|--|--|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eleanor Messick Winegrad | | 2. Date of Death
Month August Day 10, Year 2000 | | 3. Time of Death
2:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis ElderCare Spa Creek | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
214-01-0842 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 28, 1918 |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | |
| | 10a. State
MD | 10b. County
Anne Arundel | 10c. City, Town or Location
Annapolis | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
27 Heritage Court | | 10f. Zip Code
21401 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | |
| | 17. Father's Name (First, Middle, Last)
William Messick | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Lijewski | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Gerald W. Winegrad | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1328 Washington Drive, Annapolis, MD 21403 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veteran's Cemetery | | 20c. Location - City or Town, State
8-14-2000 Crownsville, MD | |
| | 21. Signature of Funeral Service Licensee
Todd Liller | | 22. Name and Address of Facility
John M. Taylor Funeral Home
147 Duke of Gloucester Street, Annapolis, MD 21401 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. CVA
Due to (or as a consequence of):
b. pneumonia
Due to (or as a consequence of):
c. Respiratory failure
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| State Registrar | 29b. Signature and title of certifier
Eric Hermansen | | 29c. License number
A00295 | | 29d. Date signed (Month, Day, Year)
Aug 10, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Eric Hermansen - 2108 Didonato Drive, Chester, MD 21619 | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 11 2000 | | 32. Registrar's Signature
B. Spauls | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27347

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTINE WHATLEY

2. Date of Death

Month Day Year
August 10 2000

3. Time of Death

12.30AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

250-27-6139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC 6 1961

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

7885 GORDON COURT

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (14 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PACKER

16b. Kind of Business/Industry

GREENWOOD PACKING COMPANY

17. Father's Name (First, Middle, Last)

HERSCHEL ATKINS

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN THOMAS

19a. Informant's Name/Relationship (Type, Print)

ERNESTINE PERRIN (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 251 HODGES, SOUTH CAROLINA 29653

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

8/15/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Larry H. Reese M00583

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNODEFICIENCY SYNDROME

Due to (or as a consequence of):

b. PNEUMOCYSTIS CARINII PNEUMONIA.

Due to (or as a consequence of):

c. CHRONIC HEPATITIS C.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

MD D45149

29d. Date signed (Month, Day, Year)

August 10 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

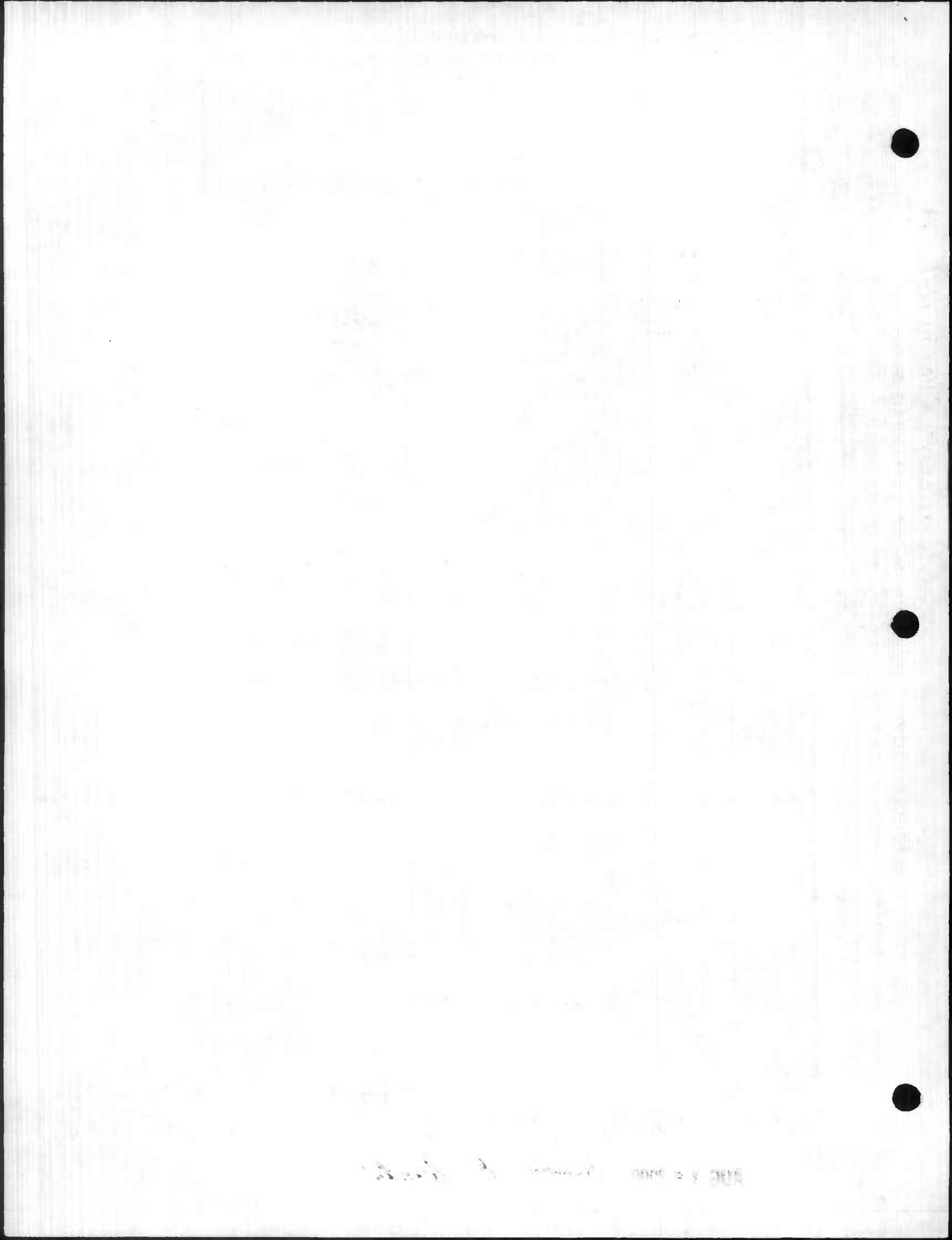
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

WATLEY CHRISTINE A



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27348

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Freddie Albert Wright

2. Date of Death

Month Day Year
Aug. 10, 2000

3. Time of Death

6:40 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

219-14-4145

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 4 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Wicomico10c. City, Town or Location
Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 Civic Avenue

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

James Shelly Wright

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Johns

19a. Informant's Name/Relationship (Type, Print)

James Curtis (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 302 Green Wood DE 19950

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Mem. Garden

Date

8/10/00

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Right leg Congestive

Due to (or as a consequence of):

c. Prolapsed Aortic Aneurysm

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 weeks

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

FREDDIE WRIGHT

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Jason Foster Wilson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27349

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jason Foster Wilson

2. Date of Death

Month

Day

Year

3. Time of Death

July 30-31

2000

12:05 P.M.

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

043-70-5431

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

22

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 13, 1977

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Conn.

10b. County

Fairfield

10c. City, Town or Location

Bridgeport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

743 Canaan Road, Building 88 Apt. 18

10f. Zip Code

06610

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Production Worker

16b. Kind of Business/Industry

Beverage Company

17. Father's Name (First, Middle, Last)

Joseph Fox Wilson, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Olive P. Moragne

19a. Informant's Name/Relationship (Type, Print)

Olive P. Moragne (Mother) Wilson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

743 Canaan Road, Building 88, Bridgeport, Ct. 06610

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Memorial Gardens

Date

8/5/00

20c. Location - City or Town, State

Keyser, West Virginia

21. Signature of Funeral Service Licensee

Hans Dean Hofmeister

22. Name and Address of Facility

Markwood Funeral Home

111 S. Mineral St., Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

7/30/00

28b. Time of Injury

(Month, Day, Year)

0610AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28d. Describe how Injury occurred

Driver of Motor Vehicle

Impacts Fixed Objects

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Interstate 30

Washington County, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner

111 Penn Street, Baltimore, Maryland 21201

31. Date signed (Month, Day, Year)

AUG 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or initials.

0005 2 9 3014

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27350

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley E. Waskiewicz

2. Date of Death

Month Day Year

Aug 10 2000

3. Time of Death

1201 AM

4a. Facility Name (If not institution, give street and number)

Solomons Nursing Center

4b. City, Town, or Location of Death

Solomons

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

169 14 8184

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) June 7 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland Calvert

10b. County

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

651 Willow Way

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

mail carrier

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Anthony Waskiewicz

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Zukowsky

19a. Informant's Name/Relationship (Type, Print)

Mildred T. Waskiewicz- wife same as #10

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

Aug 14 2000

20c. Location - City or Town, State

Carverton Pennsylvania

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home

4405 Brookes Is. Rd. Prince Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

unk

Due to (or as a consequence of):

Parkinson's Disease

years

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph J. Bell III MD

29c. License number

D0052422

29d. Date signed (Month, Day, Year)

August 10, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph Barth MD

Prince Frederick MD 20676

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Barth

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature or mark.

Small handwritten mark or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27351

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
Lillian Alice Whitby | | | | 2. Date of Death
Month Day Year
Aug. 1, 2000 | | 3. Time of Death
7:30 AM | |
| 4a. Facility Name (If not institution, give street and number)
Meredian-Corsica Hills Nursing Center | | | | 4b. City, Town, or Location of Death
Centreville | | 4c. County of Death
Queen Anne's | |
| 5. Social Security Number
213-74-3620 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
95 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 24, 1905 Maryland | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State
Md. | | 10b. County
Queen Anne's | | 10c. City, Town or Location
Queenstown | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
326 Wye Mills Road | | | | 10f. Zip Code
21658 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Self | |
| 17. Father's Name (First, Middle, Last)
Vernon Porter | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice (Unknown) | | | |
| 19a. Informant's Name/Relationship (Type, Print) Son Samuel Phillip Whitby | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5308 Main St., Grasonville, Md. 21638 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Memorial Park | | 20c. Date
Aug. 4, 2000 | | 20d. Location - City or Town, State
Easton, Md. | |
| 21. Signature of Funeral Service Licensee
Thomas K. Helfenbein | | | | 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
408 S. Liberty St., Centreville, Md. | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. acuterenal failure
Due to (or as a consequence of):</p> <p>b. failure to thrive
Due to (or as a consequence of):</p> <p>c. gastric outlet obstruction
Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>week</p> <p>week</p> <p>year</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
history of gastrointestinal bleed | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Kathleen Hoey | | | | 29c. License number
D47627 | | 29d. Date signed (Month, Day, Year)
8-1-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kathleen Hoey, M.D.: 2540 Centreville Rd., Centreville, Md. 21617 | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 03 2000 | | | | 32. Registrar's Signature
Benjamin B. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27352

| | | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Karl Harry Ziegler, Jr. | | | | | 2. Date of Death
Month August Day 4 , Year 2000 | | 3. Time of Death
3:00 am | | |
| | 4a. Facility Name (If not institution, give street and number)
16 Brookview Avenue | | | | | 4b. City, Town, or Location of Death
Pasadena | | 4c. County of Death
Anne Arundel | | |
| Funeral
Director | 5. Social Security Number
179-22-6037 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec 13, 1928 | | 9. Birthplace (State or Foreign Country)
PA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
16 Brookview Avenue | | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1948-1952 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Communications Supervisor | | | 16b. Kind of Business/Industry
Civil Service | | |
| 17. Father's Name (First, Middle, Last)
Karl H. Ziegler, Sr. | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Vera Pennypacker | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty Jeanne Ziegler/Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Brookview Avenue, Pasadena, MD 21122 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery | | Date
Aug 7 2000 | | 20c. Location - City or Town, State
Crownsville, MD | | | |
| 21. Signature of Funeral Service Licensee
<i>James E. Barranco</i> | | | | | 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy Severna Park, MD 21146 | | | | | |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
WIDELY METASTATIC PROSTATE CARCINOMA (YEARS) | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Kevin J. O'Keefe MD</i> | | | | | 29c. License number
DB5259 (MD) | | 29d. Date signed (Month, Day, Year)
8/4/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KEVIN J O'KEEFE MD 8601 VETERANS HIGHWAY MILLERSVILLE MD, 21108 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 07 2000 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint handwritten notes and markings at the bottom of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27353

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Lottie E. Beitzel | | | | 2. Date of Death
Month Aug Day 26 Year 2000 | | 3. Time of Death
16:00 PM | |
| 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | |
| 5. Social Security Number
577-03-9272 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 14, 1912 | |
| 9. Birthplace (State or Foreign Country)
Oak Forest PA | | 10. Usual Residence of Decedent
10a. State PA 10b. County Fayette 10c. City, Town or Location Masontown 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Merital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |

Funeral
Director

To Be Completed by Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| 17. Father's Name (First, Middle, Last)
Jesse W. Efav | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ellen Brookover | |
| 19a. Informant's Name/Relationship (Type, Print)
Wayne H. Beitzel Son | | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
4723 Washington Avenue Shadyside, MD 20764 | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greene County Memorial Park | | 20c. Location - City or Town, State
Waynesburg, PA | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 21230 | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
acute myocardial infarction
Due to (or as a consequence of):
CIAD
Due to (or as a consequence of):
ASVD
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
24 hrs | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street end Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> MD | | 29c. License number
D 55458 | | 29d. Date signed (Month, Day, Year)
08/26/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nancy Heisel, MD 64 Franklin, Annapolis, MD 21401 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | |

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

66-1-5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27354

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Bennett

2. Date of Death

August 24 2000

3. Time of Death

5:00 P.M.

4a. Facility Name (If not institution, give street and number)

838 Woods Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214 38 2169

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 5, 1942

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

838 Woods Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chemical Engineer

16b. Kind of Business/Industry

FMC Corporation

17. Father's Name (First, Middle, Last)

Charles L. Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Juanita McGraw

19a. Informant's Name/Relationship (Type, Print)

Tracy Bennett / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 West 11th Avenue Baltimore, Maryland 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Memorial Park 8/28/00

Date

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction -

Due to (or as a consequence of):

b. Coronary Artery Disease 12/96

Due to (or as a consequence of):

c. Aortic Stenosis 12/96

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Emphysema

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D31744

29d. Date signed (Month, Day, Year)

8-25-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAROLD G. HEBARD 4710 PENNINGTON AVE

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202.224.2000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ASEC 00

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27355

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lois May Ball | | | | 2. Date of Death
Month August Day 28 Year 2000 | | | | 3. Time of Death
11:28 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
City | |
| Funeral
Director | 5. Social Security Number
184-26-9159 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
Dec. 28, 1929 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Reisterstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 18b. Kind of Business/Industry
Homemaker | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 17. Father's Name (First, Middle, Last)
Albert J. Kottler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Hemma | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
328 Estate Rd. Reisterstown, Md. 21136 | |
| | 19a. Informant's Name/Relationship (Type, Print)
James H. Ball Sr. - husband | | | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evergreen Mem. Gardens Sept. 1, 2000 Finksburg, Md. | |
| | 21. Signature of Funeral Service Licensee
J. South Eckhardt | | | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
11605 Reisterstown Rd. Owings Mills, Md. 21117 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Pulmonary Hypertension
Due to (or as a consequence of):
b. Right sided heart failure
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
M.D. | | | | 29c. License number
AT 2438946012 | | | | 29d. Date signed (Month, Day, Year)
8.28.00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cheryl Person, M.D. 201 E. University Parkway Baltimore MD 21218 | | | | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
B. Sparks | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND#20A&B PER F.H. G786 8-29-2000 JAB

Reg. No. 00 27356

| | | | | | |
|---|---|--|---|---|-------------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Boy Bradley | | 2. Date of Death
Month March Day 17 Year 2000 | | 3. Time of Death
10:30 AM |
| | 4a. Facility Name (If not institution, give street and number)
Harbor Hospital Center | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
None | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
MA-17-2000 | | 9. Birthplace (State or Foreign Country)
MD | | |
| Usual Residence of Decedent | | | | | |
| 10e. State
MD | | 10b. County | | 10c. City, Town or Location
Baltimore | |
| 10e. Street and Number
2423 Westport Street | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Infant | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Infant | | 16b. Kind of Business/Industry
Infant | |
| 17. Father's Name (First, Middle, Last)
Sammy L. Burris | | 18. Mother's Name (First, Middle, Maiden Surname)
April Bradley | | | |
| 19a. Informant's Name Relationship (Type, Print)
April Bradley | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2423 Westport St. Balto MD 21230 | | | |
| 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) IAB | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harbor Hospital Center | | 20c. Location - City or Town, State
Balto. MD. | |
| 21. Signature of Funeral Service Licensee
N. Mally | | 22. Name and Address of Facility
Harbor Hospital Center 3001 S. Hanover St. | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Extreme Immaturity
Due to (or as a consequence of): | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | | |
| 24a. Was an autopsy performed?
1 Yes 2 No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
N. Mally | | 29c. License number
D0024099 | | 29d. Date signed (Month, Day, Year)
Aug 8, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard Popkin 3001 S Hanover Street | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
B. Sparks | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27357

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph William Cech | | | | 2. Date of Death
Month Day Year
August 24, 2000 | | 3. Time of Death
7:43 PM | |
| | 4e. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Ctr. | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-07-2309 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 13, 1914 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
7813 Harold Road | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | 16b. Kind of Business/Industry
Steel Industry | | | | |
| 17. Father's Name (First, Middle, Last)
Joseph Cechotovsky | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sadie Sloboda | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Anne J. Cech (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7813 Harold Road Dundalk, Maryland 21222 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cemetery | | 20c. Date
8/28/2000 | | 20d. Location - City or Town, State
Dundalk, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | a. <u>CANCER OF THE PROSTATE</u>
Due to (or as a consequence of):
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | | | |
| | | 29c. License number
D 38033 | | 29d. Date signed (Month, Day, Year)
8/28/00 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TRENCE F. DUBOIS 261 Highland Ave Balt. MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27358

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clementina J. Colliflower

2. Date of Death

August 17, 2000

3. Time of Death

7:52am

4a. Facility Name (If not institution, give street and number)

4518 Rutherford Way

4b. City, Town, or Location of Death

Dayton

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

219-92-8242

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 8, 1931

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Florida

10b. County

Clay

10c. City, Town or Location

Keystone Heights

10d. Inside City Limits

1 ☐ Yes ☒ No

10a. Street and Number

6465 Loch Lomond Drive

10f. Zip Code

32656

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Int. Monetary Fund

17. Father's Name (First, Middle, Last)

Juan Munoz

18. Mother's Name (First, Middle, Maiden Surname)

Matilde Riva

19a. Informant's Name/Relationship (Type, Print)

Joseph Colliflower/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6465 Loch Lomond Drive, Keystone Heights, FL 32656

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Cr. 8/19/00 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kym Schlangens

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ovarian Cancer

Approximate Interval Between Onset and Death

18 Weeks

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughter's Res.

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terri L. Cornelison

29c. License number

09234

29d. Date signed (Month, Day, Year)

8/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terri L. Cornelison, M.D. 600 North Wolfe Street, Phiggs 218, Balto., Maryland

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Benjamin S. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1912-1913

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27359

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Clarabelle Cassady</i> | | | | 2. Date of Death
Month Day Year
<i>August 27, 2000</i> | | 3. Time of Death
<i>8:30 am</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>6975 Old Dorsey Road</i> | | | | 4b. City, Town, or Location of Death
<i>Elkridge</i> | | 4c. County of Death
<i>Howard</i> | |
| Funeral
Director | 5. Social Security Number
<i>212.26.7085</i> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>76</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Dec. 20, 1923</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>Howard</i> | | 10c. City, Town or Location
<i>Elkridge</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>6975 Old Dorsey Road</i> | | 10f. Zip Code
<i>21075</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Administrative Assistant</i> | | 16b. Kind of Business/Industry
<i>U.S. Government</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>James E. Cassady</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Rovena Englehart</i> | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Jim McGregor/Nephew</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>312 Bishop Court Westminster, MD 21157</i> | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Meadowridge Mem. Park</i> | | 20c. Location - City or Town, State
<i>Elkridge, Maryland</i> | | 20d. Date
<i>8/31</i> | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>Gary L. Kaufman Funeral Home at Meadowridge Memorial Park 7250 Washington Blvd. Elkridge, MD 21075</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<i>Left Renal Cell Cancer</i> | | | | | | | Approximate Interval Between Onset and Death
<i>2 months</i> |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Anemia</i>
<i>Anorexia-Cachexia</i> | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
XX <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | 29b. Signature and title of certifier
<i>[Signature]</i> |
| To Be Completed by Physician/Medical Examiner | 29c. License number
<i>D30573</i> | | 29d. Date signed (Month, Day, Year)
<i>August 29, 2000</i> | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Jon K. Minford, M.D. 2 Knoll North Columbia, MD 21045</i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
<i>AUG 30 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |
| | State Registrar | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27360

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE GRZECOWIAK COLLINS

2. Date of Death

Month Day Year
AUGUST 24, 2000

3. Time of Death

3:20AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GILCHREST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

215-28-4070

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
5/19/31

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

JARRETTSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1913 FOREST GUARD COURT

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

COMPUTER SPECIALIST

16b. Kind of Business/Industry

BALTO. CO. LIBRARY

17. Father's Name (First, Middle, Last)

ANTHONY JOSEPH GRZECOWIAK

18. Mother's Name (First, Middle, Maiden Surname)

MARIE HELENA CLARK

19a. Informant's Name/Relationship (Type, Print)

WILLIAM H. COLLINS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1913 FOREST GUARD COURT JARRETTSVILLE, MD. 21084

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DULANEY VALLEY MEM.

Date

8/28

20c. Location - City or Town, State

COCKEYSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME P.A.

2525 FLEET ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. is chemically left Hemispheric stroke

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

12 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospital

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

025205

29d. Date signed (Month, Day, Year)

August 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley 6800 1st St. Balto. md 21204

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

State
RegistrarCollins, Marie AUGUST 24, 2000 @ 3:20 AM
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27361

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Farrell Didas

2. Date of Death

August 29, 2000

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

911 W. Lake Avenue

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

579-62-5337

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

Oct. 27, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

911 W. Lake Avenue

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Roman Catholic Priest

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

George Albert Didas

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Farrell

19a. Informant's Name/Relationship (Type, Print)

St. Joseph Society of the Sacred Heart

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1130 N. Calvert Street Baltimore, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 9-2-00 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Paul L. Hentrich Jr.

22. Name and Address of Facility

Baltimore, Maryland 21214
Leonard J. Ruck, Inc. 5305 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure
Due to (or as a consequence of):b. Renal Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Labaco 7505 Foster Drive Towson MD 21204

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Form 1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27362

Amended Item# 9 per FH G786 8-31-00 WJJ
Amended Item# 24a per FH G786 8-30-00 WJJ

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|--|---|--|--|---|--|---|---------------|--|----------------------------------|---|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Rita M. Dombrowski</i> | | | 2. Date of Death
Month <i>08</i> Day <i>28</i> Year <i>00</i> | | 3. Time of Death
<i>7:15 pm</i> | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Good Samaritan Hosp</i> | | | 4b. City, Town, or Location of Death
<i>Balt. MD 21239</i> | | 4c. County of Death
<i>N/A</i> | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>213 14 3124</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>78</i> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Nov. 21, 1921</i> | | | | | | |
| | 9. Birthplace (State or Foreign Country)
<i>USA MD.</i> | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 10e. Street and Number
<i>6401 LOCH RAVEN BLVD APT 832</i> | | | 10f. Zip Code
<i>21239</i> | | 10g. Citizen of What Country?
<i>USA</i> | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6 yrs</i> College (1-4or 5+) <i>N/A</i> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>HOME MAKER</i> | | 16b. Kind of Business/Industry
<i>OWN HOME</i> | | | | | | | |
| 17. Father's Name (First, Middle, Last)
<i>JOHN WAGNER</i> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>MARY REZULAK</i> | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>SUSAN WILLIAMS DAUGHTER</i> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5920 PLUMER AVE BALTO MD 21206</i> | | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>ST. STANISLAUS CEMETERY</i> | | 20c. Location - City or Town, State
<i>8/31/00 BALTIMORE, MD</i> | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>Robert E. Attenberg Lic D00002</i> | | | 22. Name and Address of Facility
<i>ALTENBURG FUNERAL HOME, PA.
6009 HARRFORD ROAD BALTIMORE, MD 21214</i> | | | | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of):

 Due to (or as a consequence of): </td> <td>a. <i>CHF</i></td> <td rowspan="4"> Approximately
Interval Between
Onset and Death </td> </tr> <tr> <td>b. <i>coronary insufficiency</i></td> </tr> <tr> <td>c. <i>& ischemic cardiomyopathy</i></td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | a. <i>CHF</i> | Approximately
Interval Between
Onset and Death | b. <i>coronary insufficiency</i> | c. <i>& ischemic cardiomyopathy</i> | d. |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | a. <i>CHF</i> | Approximately
Interval Between
Onset and Death | | | | | | | | | | |
| | b. <i>coronary insufficiency</i> | | | | | | | | | | | |
| | c. <i>& ischemic cardiomyopathy</i> | | | | | | | | | | | |
| | d. | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<i>NA</i> | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dr. [Signature] Attending Physician</i> | | | 29c. License number
<i>D24916</i> | | 29d. Date signed (Month, Day, Year)
<i>8/28/00</i> | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 25e) (Type, Print)
<i>5601 Loch Raven Blvd Balt. MD 21239</i> | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 30 2000</i> | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

"nature", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27363

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Laura Newkirk Elvidge | | | | 2. Date of Death
Month Day Year
AUGUST 27, 2000 | | 3. Time of Death
2:16 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218 40 4672 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 15, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Anne Arundel | | | 10c. City, Town or Location
Pasadena | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number
1177 Ridge Drive | | | 10f. Zip Code
21122 | | |
| 10g. Citizen of What Country?
U.S. | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 years | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | 17. Father's Name (First, Middle, Last)
William H. Newkirk | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
florence Barrett | | | 19a. Informant's Name/Relationship (Type, Print)
Florence Bankey / Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1177 Ridge Drive Pasadena, Maryland 21122 | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | | 20c. Location - City or Town, State
8/29/00 Towson, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Donna M. Zimnirouski</i> | | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
diabetes | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Joanne Saunders</i> | | | 29c. License number
033061 | | | 29d. Date signed (Month, Day, Year)
August 27, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joanne Saunders St Agnes Healthcare Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | 32. Registrar's Signature
<i>Sparks</i> | | | | | |

ORIGINAL

10/10/13

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27364

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred Pearl Franks | | | | 2. Date of Death
Month Day Year
August 27, 2000 | | 3. Time of Death
8:00 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Chapel Hill Nursing Center | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
216-18-4588 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
82 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 24, 1918 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
8309 Mindale Circle | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Samuel Crouse | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Genevieve Adams | | 19a. Informant's Name/Relationship (Type, Print)
Myrna Lee Hart Greenwell/Daugh. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Shady Nook Avenue, Catonsville, MD 21228 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 21. Signature of Funeral Service Licensee
Witzke Funeral Homes, Inc. | | 22. Name and Address of Facility
630 Edmondson Avenue, Catonsville, MD 21228 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RESPIRATORY FAILURE
Due to (or as a consequence of):
b. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
c. DISEASE
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
1 HOURS
10 YEARS | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Deborah I. Pierce | |
| State Registrar | 29c. License number
1145931 | | 29d. Date signed (Month, Day, Year)
August 29, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deborah I. Pierce 1220 PARK HEIGHTS AVENUE BALTIMORE MD | | 31. Data filed (Month, Day, Year)
AUG 30 2000 | |
| | 32. Registrar's Signature
S. Sparks | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

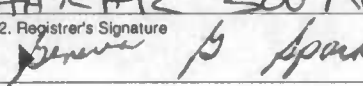
00 27365

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTY RUTH GUZZONE | | | 2. Date of Death
Month Day Year
AUGUST 28, 2000 | | 3. Time of Death
2:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
MANOR CARE | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
234-36-4661 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
2-22-1925 | |
| | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
ROSEDALE | |
| Usual Residence of Decedent | | 10e. Street and Number
1609 WEYBURN ROAD | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | | |
| 17. Father's Name (First, Middle, Last)
HERBERT P. HUTZLER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
STELLA (MORRIS) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BRIAN GUZZONE (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2925 JOHNSON ROAD FALLS CHURCH, VA 22042 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH CEMETERY | | Date
8/30/00 | | 20c. Location - City or Town, State
ROSEDALE, MD | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVENUE ROSEDALE, MD 21237 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOMA
Due to (or as a consequence of):
b. PULMONARY CARCINOMA
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D24100 | | 29d. Date signed (Month, Day, Year)
08-29-2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M.L. PRAZHAKAR 300 ARMORY PLACE BAL, MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
 | | | | | | |

ORIGINAL

00-4841-510

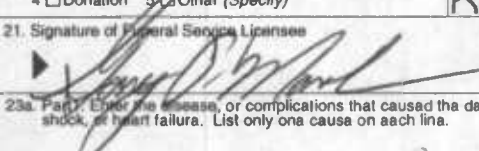
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TANYA
GRIFFIN

AMEND ITEMS: #23 PART I, 27, 28A-F, PER MFG 787 9-6-00 WR. 00

Certificate of Death

Reg. No. 27366

| | | | | | | | | | |
|--|---|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Tanya Y. Griffin | | | | 2. Date of Death
Month AUGUST Day 26 , Year 2000 | | 3. Time of Death
8:00P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
214-64-5799 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 22, 1964 Maryland | | |
| | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
3933 Clarks Lane Apt. D | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cake Decorator | | 16b. Kind of Business/Industry
Wholesaler | | | | | |
| 17. Father's Name (First, Middle, Last)
Bobby L. Griffin | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ruby Streater | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Terry Owens - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3933 Clarks Lane Apt. D Balto, MD. 21215 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Park | | 20c. Location, City or Town, State
Sept. 1, 00 Randallstown, MD. | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
5446 Fredrickson Pass Balto, MD. 21229 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

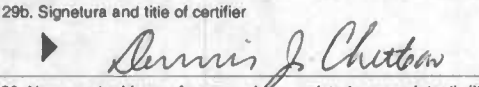
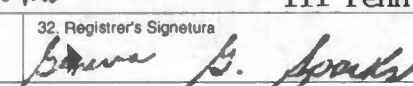
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

ACUTE COCAINE AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 8-26-00 | | 28b. Time of Injury
UNKNOWN | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND IN HALLWAY OF BLDG. | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3600 OAKMONT AVE BALTIMORE, MD. | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 27, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutkan | | | | 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
 | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27367

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Claude Waund Garry

2. Date of Death

August 25, 2000

3. Time of Death

7:30am

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

207-16-8860

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 3, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10001 Windstream Drive

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Entrepreneur

16b. Kind of Business/Industry

Social Services

17. Father's Name (First, Middle, Last)

Claude W. Garry

18. Mother's Name (First, Middle, Maiden Surname)

Marie Turner

19a. Informant's Name/Relationship (Type, Print)

Myrna E. Garry/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10001 Windstream Drive, Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mon Valley Memorial Park

Date

8/30/00

20c. Location - City or Town, State

Donora, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Road, Columbia, Maryland 21045

23a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Approximate Interval Between Onset and Death

2 days

Due to (or as a consequence of):

b. Acute Renal Failure

2 days

Due to (or as a consequence of):

c. Pneumonia

1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Acosta MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

August 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Acosta MD - 2401 West Belvedere Avenue, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

B. Acosta

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

PER. MEO G7879-6-00 WR.

Certificate of Death

Reg. No. 00 27368

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Amber Denise Horton | | | | 2. Date of Death
Month August Day 23 Year 2000 | | 3. Time of Death
2:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-13-8381 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
13 Yrs. | | 8. Date of Birth (Month, Day, Year)
09-25-1986 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
811 W. Lexington St. | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 th College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
School | | 17. Father's Name (First, Middle, Last)
Rudolph Horton | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Priscilla Elizabeth Timmons | | 19a. Informant's Name/Relationship (Type, Print)
Priscilla E. Horton (Mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
811 W. Lexington St. Balto., Md. 21201 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | 20c. Date
8/29/00 | | 20d. Location - City or Town, State
Landsdowne, Maryland | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
Cable Funeral Service | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ACUTE AMITRIPTYLINE INTOXICATION | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year)
8-22-00 | | 28b. Time of Injury
8:00 | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT INGESTED DRUG | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND IN DWELLING | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
806 W. LEXINGTON STREET BALTIMORE, MD | | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | |
| 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 24, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | |
| 32. Registrar's Signature
 | | 33. State Registrar
State Registrar | | 34. DHMH 16 Rev 6/95 | | 35. ORIGINAL | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27369

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)
Lewis Frank Herbst | | 2. Date of Death
Month August Day 28 Year 2000 | | 3. Time of Death
9:55 p.m. | |
| 4a. Facility Name (If not institution, give street and number)
Future Care Old Court | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore Co. |
| 5. Social Security Number
578-01-1315 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 26, 1910 |
| 9. Birthplace (State or Foreign Country)
Connecticut | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Woodlawn | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
7103 Iverson Court | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Builder | | 16b. Kind of Business/Industry
Pipe Organs | |
| 17. Father's Name (First, Middle, Last)
Frank Herbst | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Nodine | | |
| 19e. Informant's Name/Relationship (Type, Print)
Mr. Donald L. Herbst - Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7103 Iverson Court Baltimore, Maryland 21244 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | 20c. Location - City or Town, State
8/31/2000 Baltimore, MD | |
| 21. Signature of Funeral Service Licensee
Michael E. Canapp | | 22. Name and Address of Facility
5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebrovascular accident | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
F. Kawaja | | 29c. License number
DA5112 | | 29d. Date signed (Month, Day, Year)
8/29/2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TAHOORA KAWAJA 20, Crossroads Dr Suite 101 Owings Mills MD 21117 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
Sparks | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27370

| | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|---|---------------------|--|----------------------------------|--|------------------------------------|---------------|----------------------------------|--|---|------------------|----------------|----------------------------------|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Frances M. Ichniowski | | | | 2. Date of Death
Month Aug Day 28 Year 2000 | | 3. Time of Death
10:20 pm | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
216-09-7242 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 16, 1912 | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
3601 Greenway Unit 904 | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bank Teller | | 16b. Kind of Business/Industry
Bank | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Walenty Ichniowski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Tomasziewicz | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Rev. Stephen E. Jeselnik - Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4001 Roundtop Rd. Baltimore, MD 21218 | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cemetery | | Date
9-1-00 | | 20c. Location - City or Town, State
Baltimore, MD | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Paul L. Hartbock Jr. | | | | 22. Name and Address of Facility
Baltimore, Maryland 21214
Leonard J. Ruck, Inc. 5305 Harford Rd. | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Pneumonia</td> <td>Approximate Interval Between Onset and Death
3 days.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Congestive Heart Failure</td> <td>3 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Sepsis</td> <td>3 days.</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | Approximate Interval Between Onset and Death
3 days. | Due to (or as a consequence of): | | b. Congestive Heart Failure | 3 days | Due to (or as a consequence of): | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Sepsis | 3 days. | Due to (or as a consequence of): | | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | Approximate Interval Between Onset and Death
3 days. | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Congestive Heart Failure | 3 days | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Sepsis | 3 days. | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Leukemia | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
John Stratidis | | 29c. License number
AT2438946 | | 29d. Date signed (Month, Day, Year)
08/28/00 | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Stratidis 4404 Falls Bridge Dr. Apt #K Baltimore, MD 21211 | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
James B. Sparks | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-0020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27371

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sophie

2. Date of Death

Month Day Year
August 28 2000

3. Time of Death

1:05 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-32-5729

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 15 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2517 Liberty Parkway

10f. Zip Code

21222

10g. Citizen of What Country?

U.S. of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew

18. Mother's Name (First, Middle, Maiden Surname)

Szczechowiak

Frances

Teclqw

19a. Informant's Name/Relationship (Type, Print)

Benigna S. Hall (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2608 Ambler Road Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St' Stanislaus

Date

August

30

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Mark A. Pognach

22. Name and Address of Facility

W. Dabrowski-Chojnacki F.H.'s P.A.

1005 Dundalk Ave. Balto., Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End-Stage Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

8/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulany Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Tariq Mahmood

State
RegistrarAugust 28, 2000 1:05 a.m.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sophie Janiszewski
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27372

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Margaret Jefferies</i> | | | | 2. Date of Death
Month <i>August</i> Day <i>28</i> Year <i>2000</i> | | 3. Time of Death
<i>4:50 pm</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>736 Chessie Crossing Way</i> | | | | 4b. City, Town, or Location of Death
<i>Woodbine</i> | | 4c. County of Death
<i>Howard</i> | |
| Funeral
Director | 5. Social Security Number
<i>143.28.8092</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>85</i> Yrs. | | 8. Date of Birth
Month <i>Sept.</i> Day <i>8</i> Year <i>1914</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Kentucky</i> | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
<i>MD</i> | | 10b. County
<i>Howard</i> | | 10c. City, Town or Location
<i>Woodbine</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
<i>736 Chessie Crossing Way</i> | | | | 10f. Zip Code
<i>21797</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>1</i> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Dental Nurse</i> | | | 16b. Kind of Business/Industry
<i>HealthCare</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>John A. Trostle</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Frances Blue</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Fitch B. Jefferies, Sr./Husband</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>736 Chessie Crossing Way Woodbine, MD 21797</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Meadowridge Mem. Park</i> | | Date
<i>9/1/00</i> | | 20c. Location - City or Town, State
<i>Elkridge, MD</i> | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>Gary L. Kaufman Funeral Home at Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, Md 21075</i> | | | |
| | Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
<i>Coronary Heart Failure</i> | | | | | | <i>2 weeks</i> | | |
| Due to (or as a consequence of):
<i>Coronary artery disease</i> | | | | | | <i>> 1 yr.</i> | | |
| Due to (or as a consequence of): | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Diabetes</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
<i>136716</i> | | 29d. Date signed (Month, Day, Year)
<i>Aug 29, 2000</i> | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Andrew Kundra, M.D. 8317 Cherry Lane, Laurel, 20707</i> | | | | | | | |
| | State
Registrar | 31. Date filed (Month, Day, Year)
<i>Aug 30 2000</i> | | | | 32. Registrar's Signature
<i>[Signature]</i> | | |

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27373

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Warren Gene Johnson</u> | | | | 2. Date of Death
Month Day Year
<u>August 27, 2000</u> | | | | 3. Time of Death
<u>8:06 A.M.</u> | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>360 South Dukeland Street</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | | | 4c. County of Death
<u>N/A</u> | | |
| Funeral
Director | 5. Social Security Number
<u>218-46-9825</u> | | 6. Sex
<u>M</u> <input type="checkbox"/> F <input type="checkbox"/> | | 7. Age (In yrs. last birthday)
<u>52</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>07-02-48</u> | | 9. Birthplace (State or Foreign Country)
<u>M.D.</u> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
<u>M.D.</u> | | 10b. County
<u>NA</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
<u>1213 Greenmount Ave.</u> | | | | 10f. Zip Code
<u>21202</u> | | 10g. Citizen of What Country?
<u>USA</u> | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Year or Dates: <u>1967-1969</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>AFRICAN AMERICAN</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+) <u>-0-</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Self Employed Business</u> | | 16b. Kind of Business/Industry
<u>Produce Market</u> | | | | | |
| 17. Father's Name (First, Middle, Last)
<u>Earl Purnell</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Agnes Johnson</u> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>Anna E. Johnson</u> wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1213 Greenmount Ave Baltimore, MD 21202</u> | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Garrison Vet Cemetery</u> | | Date
<u>08-31-00</u> | | 20c. Location - City or Town, State
<u>OWINGS MILLS, M.D.</u> | | | | | |
| 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>Wylie Funeral Home PA</u>
<u>638 N. Gilmer Street Baltimore, MD 21217</u> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Diabetes Mellitus, Congestive Heart Failure</u> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<u>Inspection</u>
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>at scene</u> | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>[Signature]</u> | | | | 29c. License number
<u>O.C.M.E.</u> | | 29d. Date signed (Month, Day, Year)
<u>August 27, 2000</u> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201</u> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 30 2000</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

00-4864-510
JOE L. LAWSON
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27374

amend item 20b per fh G787 9/6/00 yf

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---------------------------------|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joe Lewis Lawson | | 2. Date of Death
Month AUGUST Day 28 , Year 2000 | | 3. Time of Death
03:25 A.M. |
| | 4a. Facility Name (If not institution, give street and number)
1941 BOOTH STREET | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
212-32-9108 | 6. Sex
1 M 2 F | 7. Age (In yrs, last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth
(Month, Day, Year)
October 9, 1936 | | 9. Birthplace (State or Foreign Country)
NC | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
1 Yes 2 No | | | | |
| To Be Completed by Physician/Medical Examiner | 10e. Street and Number
1941 Booth Street | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc.
Specify: African American | | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Fork Lift Operator |
| | 16b. Kind of Business/Industry
Box Company | | 17. Father's Name (First, Middle, Last)
Alfred Lawson | | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
Mollie Lawson | | 19. Informant's Name/Relationship (Type, Print)
Pandora G. Jones | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2612 Kent Street Baltimore MD 21230 | | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery | | 20c. Location - City or Town, State
9-1-00 Lansdowne, MD | | 21. Signature of Funeral Service Licensee
[Signature] |
| | 22. Name and Address of Facility
Wyle Funeral Home PA 21217
638 S. Belmor St. Baltimore MD | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
a. _____
b. _____
c. _____
d. _____
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed?
INSPECTION
1 Yes 2 No | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | 25. Was case referred to medical examiner?
1 Yes 2 No | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE | | 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | |
| | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 29, 2000 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

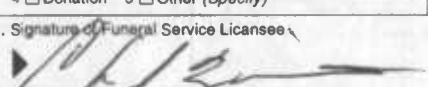
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

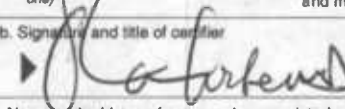

00 27375

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ian Gregory Landies | | | | 2. Date of Death
Month AUGUST Day 27 Year 2000 | | 3. Time of Death
14:10 PM | |
| | 4a. Facility Name (If not Institution, give street and number)
1573 THEODORE ROAD | | | | 4b. City, Town, or Location of Death
NORTHEAST | | 4c. County of Death
CECIL | |
| Funeral
Director | 5. Social Security Number
273-48-3518 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
50 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 24 1950 | |
| | 9. Birthplace (State or Foreign Country)
Ohio | | 10a. State
Ohio | | 10b. County
Geauga | | 10c. City, Town or Location
Munson Township | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
10840 Nollwood Drive | | 10f. Zip Code
44024 | | 10g. Citizen of What Country?
U S A | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Crane Operator | | 16b. Kind of Business/Industry
Construction | | | | |
| 17. Father's Name (First, Middle, Last)
Robert W. Landies | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Heil | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Victoria (Vicki) Landies Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10840 Nollwood Dr. Chardon, OH 44024 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chardon Municipal Cemetery | | 20c. Location - City or Town, State
Chardon Village, OH | | 20d. Date
Aug 31 2000 | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Port Ave. Baltimore Maryland 21230 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Head and chest injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8/27/00 | | 28b. Time of Injury
1352 M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred
Driver in auto accident | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
DRAG-STRIP | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cecil County Dragstrip | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. L. A. K. O. L. O. K. E., MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27376

Amended Item#26 per PHYG786 8/30/2000 EW

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Leonard Martin, Sr. | | 2. Date of Death
Month Day Year
August 25, 2000 | | 3. Time of Death
4:34 AM |
| | 4a. Facility Name (If not institution, give street and number)
1800 Belle Avenue | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
214-24-7743 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
May 21, 1929 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| 10e. Street and Number
1800 Belle Avenue | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Tool & Die Maker | | 16b. Kind of Business/Industry
Western Electric | | | |
| 17. Father's Name (First, Middle, Last)
Francis A. Martin | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Reiser | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Martha P. Martin (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1800 Belle Avenue Dundalk, Maryland 21222 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. 8/28/2000 | | 20c. Location - City or Town, State
Rosedale, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Emphysema
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
10 years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Panding investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D21846 | | 29d. Date signed (Month, Day, Year)
8/25/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Sheridan, M.D. 6830 Hospital Drive Suite 102 Baltimore, Maryland | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27377

Amended Item #24a per PHYG786 8/30/2000 EW

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Carrie Poulson</u> | | 2. Date of Death
Month <u>August</u> Day <u>6th</u> Year <u>2000</u> | | 3. Time of Death
<u>7:26 PM</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>University of Maryland Medical System</u> | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> |
| Funeral
Director | 5. Social Security Number
<u>213-74-9252</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>94</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<u>Mar 1, 1906</u> | | 9. Birthplace (State or Foreign Country)
<u>unk</u> | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
<u>MD</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
<u>213 Light Street</u> | | | 10f. Zip Code
<u>21230</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| 11. Marital Status
<u>unk</u>
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>unk</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>black</u> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>unk</u> College (1-4 or 5+) <u>unk</u> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>unk</u> | | 16b. Kind of Business/Industry
<u>unk</u> |
| 17. Father's Name (First, Middle, Last)
<u>unk</u> | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>unk</u> | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>University of MD Medical System</u> | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>22 S. Greene Street Baltimore, MD 21201</u> | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>in state</u> | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>in state</u> | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee
<u>Ronald S. Wade, Director</u> | | | 22. Name and Address of Facility
<u>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</u> | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <u>Atherosclerotic cardiovascular disease</u> | | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. <u>Coronary artery disease</u> | | Due to (or as a consequence of): | |
| | | c. | | Due to (or as a consequence of): | |
| | | d. | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<u>Emergency Physician</u> | | 29c. License number
<u>D0056240</u> | | 29d. Date signed (Month, Day, Year)
<u>August 11, 2000</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Marcia Carr 22 S. Greene St Baltimore MD 21201</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 30 2000</u> | | 32. Registrar's Signature
<u>Benita B. Sparks</u> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27378
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|---------------------------------------|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lavie A. Pachilis | | | | 2. Date of Death
Month Day Year
August 28, 2000 | | | 3. Time of Death
5:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Nursing Center-Rossville | | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
226-30-2765 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 10, 1915 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Perry Hall | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1 Forge Hill Road | | | | 10f. Zip Code
21128 | | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Factory Worker | | | 16b. Kind of Business/Industry
Manufacturing | | |
| | 17. Father's Name (First, Middle, Last)
William Akers | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Sawyer | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Edward E. Pachilis (husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Forge Hill Rd., Perry Hall, MD 21128 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Nema of cemetery, crematory or other place)
Holly Hill Mem'l Gardens | | 20c. Date
8/31/00 | | 20d. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Malet | | | | 22. Name and Address of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21236 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Heart Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
P. Raguraj MD | | | | 29c. License number
D 53720 | | | 29d. Date signed (Month, Day, Year)
08/29/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Raguraj, 2112 Belair Rd #9, Fallston, MD 21047 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
Benjamin B. Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27379

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET L. PODLES

2. Date of Death

Month Day Year
AUGUST 24, 2000

3. Time of Death

8:35PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

CANTON HARBOR NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

212-20-8419

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/22/25

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

807 S. STREEPER STREET

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

FRANCIS ETMANSKI

18. Mother's Name (First, Middle, Maiden Surname)

LUCY CZAPSKA

19a. Informant's Name/Relationship (Type, Print)

GERALD PODLES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

807 S. STREEPER ST. BALTO., MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY CEME.

Date

8/28

20c. Location - City or Town, State

DUNDALK, MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME P.A.

2525 FLEET ST. BALTIMORE, MD. 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular Disease*
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetic mellitus**Cardiovascular accident*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-18151

29d. Date signed (Month, Day, Year)

8/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chi-Shiang Chen, M.D. 301 St. Paul Place # 409 Balto, MD 21202

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27380

| | | | | | | | | | |
|--|---|---|---|---|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Lee Petchik | | | | 2. Date of Death
Month Day Year
AUG. 23 2000 | | 3. Time of Death
5:52 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
9427 Lovat Rd. | | | | 4b. City, Town, or Location of Death
Fulton | | 4c. County of Death
Howard | | |
| Funeral
Director | 5. Social Security Number
219-56-0176 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
53 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
APR. 18, 1947 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Howard | | 10c. City, Town or Location
Fulton | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
9427 Lovat Rd. | | | | 10f. Zip Code
20759 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Manager | | | 16b. Kind of Business/Industry
Real Estate | | |
| | 17. Father's Name (First, Middle, Last)
William M. Lyons | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Billie G. McCoy | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carl Petchik - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9427 Lovat Rd., Fulton, Md. 20759 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cemetery | | 8/28/00 | | 20c. Location - City or Town, State
Crownsville, Md. | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> MD/142 | | | | 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Rd., Laurel, Md. 20707 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Metastatic Ovarian Cancer</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
<i>8 months</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Nicholas M. Roudsides</i> | | | | 29c. License number
D38509 | | 29d. Date signed (Month, Day, Year)
August 25 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Nicholas M. Roudsides 1106 S Little Paxson Pkwy Columbia MD 21044</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27381

AMEND ITEMS: #88PER F.H. G787 9-14-00

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert | | 2. Date of Death
Month AUGUST Day 24 Year 2000 | | 3. Time of Death
2:15 p.m. |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death |
| Funeral
Director | 5. Social Security Number
223-80-8093 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
47 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Aug. 11, 1953 | | 9. Birthplace (State or Foreign Country)
Virginia | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
VA | | 10b. County
Shenandoah | | 10c. City, Town or Location
Toms Brook | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
68 Cecelia Street | | | 10f. Zip Code
22660 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Surveyor | | 16b. Kind of Business/Industry
VDOT | |
| 17. Father's Name (First, Middle, Last)
Robert Pence, Jr. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ann Sager | | |
| 19a. Informant's Name/Relationship (Type, Print)
Phyllis Miller Pence/Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
68 Cecelia Street, Toms Brook, Virginia 22660 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul's Lutheran Ch. C8/27/00 | | 20c. Location - City or Town, State
Jerome, Virginia | |
| 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, MD 21045 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Hepatorenal syndrome
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 day | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Graft vs. Host Disease
Due to (or as a consequence of): | | 90 days | |
| | | c. CML 4p all BMT
Due to (or as a consequence of): | | 1 yr. | |
| | | d. | | | |
| | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
DEA BS6108307 | | 29d. Date signed (Month, Day, Year)
8/24/00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Koutc. Shuk 600 N. Wolfe St Baltimore MD 21287 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
[Signature] | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27382

| | | | | | | | | |
|--|--|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARTHA ROSE RUSSELL | | | | 2. Date of Death
Month Day Year
AUGUST 26, 2000 | | 3. Time of Death
12:10pm | |
| | 4a. Facility Name (If not institution, give street and number)
8623 Philadelphia Road | | | | 4b. City, Town, or Location of Death
ROSEDALE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
213-32-9673 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
7-24-1935 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
ROSEDALE | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8623 PHILADELPHIA ROAD | | | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLAIMS DEPARTMENT | | | 16b. Kind of Business/Industry
VETERAN AFFAIRS | |
| 17. Father's Name (First, Middle, Last)
CHARLES J. HUDAK, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PAULINE (HLAVINKA) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CHRISTINA BARBER (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1004 S. CARROLL STREET HAMPSTEAD, MD 21074 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY | | Date
8/28/00 | | 20c. Location - City or Town, State
CATONSVILLE, MD |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVENUE ROSEDALE, MD 21237 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Squamous Cancer neck
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive Lung Disease
Atherosclerotic Cardiovascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Cecilia L. Ude M.D. | | | | 29c. License number
041614 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan Halle 4920 Campbell Blvd. White Marsh, MD 21236 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
 | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27383

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine

2. Date of Death

Month Day Year
Aug 24, 2000 2005

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

152-20-9848

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 6, 1928

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7080 Cradle Rock Way

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Data Processor

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Adolph Martin

18. Mother's Name (First, Middle, Maiden Surname)

Edith Geigold

19a. Informant's Name/Relationship (Type, Print)

Kim Rodriguez/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9018 Early April Way, Columbia, Maryland 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

8/29/00

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

Kim Schlegel

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. obesity hypovolemia shock 2 years

Due to (or as a consequence of):

b. morbid obesity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

emphysema
congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dany Kaplun

29c. License number

D41817

29d. Date signed (Month, Day, Year)

Aug 25, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gary Kellowm 10805 Hickory Ridge Rd Columbia Md 21045

31. Date Filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Benny B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27384

Amended Item #30 per DVR G787 9/1/2000 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL ROBISON

2. Date of Death

Month Day Year
08 27 2000

3. Time of Death

0315

4a. Facility Name (If not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-07-9713

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09/24/04

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

420 E. Clement Street

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Warehouse

17. Father's Name (First, Middle, Last)

Iaasc Robison

18. Mother's Name (First, Middle, Maiden Surname)

Anna Paul

19a. Informant's Name/Relationship (Type, Print)

John J. Robison / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

251 Allwood Drive Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

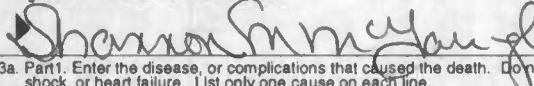
Date

8/29/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Bradycardia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease
Due to (or as a consequence of):c. Hypertension
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

08/27/00

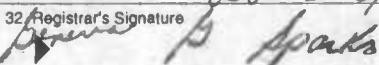
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHY JACKSON 22 S. GREENE ST, BALTO, MD 21201

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27385

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEWIS CALVIN SMITH SR. | | 2. Date of Death
Month AUG. Day 19, Year 2000 | | 3. Time of Death
7:00 AM |
| | 4a. Facility Name (If not institution, give street and number)
3408 Rockwood Ave | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
245-34-4491 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Jan. 7, 1929 | | 9. Birthplace (State or Foreign Country)
North Carolina | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
md. | | 10b. County
N/A |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
3408 Rockwood Ave | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (14 or 5+) 1 year | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
mechanic | |
| 16b. Kind of Business/Industry
Sugar factory | | 17. Father's Name (First, Middle, Last)
JOHN ROGER Smith | | 18. Mother's Name (First, Middle, Maiden Surname)
Phlonia Robinson | |
| 19a. Informant's Name/Relationship (Type, Print)
Gladys Smith - wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3408 Rockwood Ave. Balto. md. 21215 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet. | | 20c. Location - City or Town, State
8/30/00 Owings Mills, md. | |
| 21. Signature of Funeral Service Licensee
Lewis T. Gwynn | | 22. Name and Address of Facility
Lewis T. Gwynn Funeral Home
4517 Park Heights Ave. Balto. md. 21215 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Probable Myocardial Infarction
Due to (or as a consequence of):
b. Hypertensive atherosclerotic
Due to (or as a consequence of):
c. Heart Disease
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
Rifat Aboussy MD | | 29c. License number
012729 | | 29d. Date signed (Month, Day, Year)
8/22/2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rifat Aboussy MD 2000 Garrison Blvd. suite 280 | | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | |
| 32. Registrar's Signature
Benjamin B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27386

Certificate of Death

Reg. No.

LOLA
SILVESTRIPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOLA PRUITT SILVESTRI

2. Date of Death

AUGUST

Day Year
27, 2000

3. Time of Death

9:35 P.M.

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

214-24-6031

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 1, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20 SOUTH BEAUMONT

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

MD STATE GOVERNMENT

17. Father's Name (First, Middle, Last)

RAYMOND EUGENE PRUITT

18. Mother's Name (First, Middle, Maiden Surname)

EDNA P. HART

19a. Informant's Name/Relationship (Type, Print)

MARK SILVESTRI/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

219 OAK FOREST AVENUE, CATONSVILLE, MARYLAND 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

8/30/00

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

► *Shanda L. Lemmon*

M0074

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. **Arteriosclerotic Cardiovascular Disease**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

INSPECTION

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *J.M. [Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUGUST 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPLE M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

*[Signature]*State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permissible. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 18,19b per informant G787 9/6/00 yf State of Maryland / Department of Health and Mental Hygiene 00 27387
Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN SWITAJ | | 2. Date of Death
Month Day Year
AUGUST 22 2000 | | 3. Time of Death
1:50PM |
| | 4e. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE City |
| Funeral
Director | 5. Social Security Number
165 16 2857 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | 8. Date of Birth (Month, Day, Year)
Jan. 8, 1920 | 9. Birthplace (State or Foreign Country)
Pennsylvania |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
317 Frankle Street | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) Payroll | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry
Silk & Rubber Mill | | |
| | 17. Father's Name (First, Middle, Last)
Julius Reppe | | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Bander Josephine Bänder | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Susan Zickler / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
420 Fairway Estates Drive Blountville, Tenn. 37617 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Saints Cemetery | | 20c. Location - City or Town, State
8/26/00 Elysburg, Pennsylvania |
| | 21. Signature of Funeral Service Licensee
<i>Jerome Znamenski</i> | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. SEPSIS | | Approximate Interval Between Onset and Death
3 DAYS |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. URINARY TRACT INFECTION | | 7 DAYS. |
| | | | c. Due to (or as a consequence of): | | |
| | | | d. Due to (or as a consequence of): | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NON INSULIN DEPENDENT DIABETES MELLITUS
CORONARY ARTERY DISEASE
ALZHEIMERS DEMENTIA. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>Summet Sawhney (PGY-4)</i> | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
08/22/00 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUMMET SAWHNEY 3001 SOUTH HANOVER STREET, BALTIMORE, 21225 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
<i>Benita Sparks</i> | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G787 9-14-00 WR. 00 27388

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Courtney Baker Slosman | | | | 2. Date of Death
Month AUGUST Day 27 Year 2000 | | 3. Time of Death
15:58 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
549-85-5371 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
28 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 21, 1972 | | |
| | 9. Birthplace (State or Foreign Country)
Kansas | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
2320 Noonham Road | | | | 10f. Zip Code
21244 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dispatcher | | | 16b. Kind of Business/Industry
Ambulance Company | | |
| 17. Father's Name (First, Middle, Last)
John F. Baker | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Kay Armstrong Baker | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Brian D. Slosman/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2320 Noonham Road, Baltimore, Maryland 21244 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Washington Cr. | | 20c. Date
8/31/00 | | 20d. Location - City or Town, State
Laurel, Maryland | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road, Columbia, Maryland 21045 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

MEPERIDINE INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
INTRAUTERINE PREGNANCY | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
8-27-00 | | 28b. Time of Injury
UNKNOWN | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
HOME | | 28d. Describe how injury occurred
UNKNOWN | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2320 NOONHAM RD. RANDALLSTOWN, MD | | | | | | | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 28, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. ALAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27389

Amended Item#7,8 per FHG786 8/30/2000 EW

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Phyllis Smith</i> | | 2. Date of Death
Month <i>August</i> Day <i>26</i> Year <i>2000</i> | | 3. Time of Death
<i>1:50am</i> |
| | 4a. Facility Name (if not institution, give street and number)
<i>Sidai Hospital</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>NA</i> |
| Funeral
Director | 5. Social Security Number
<i>219-26-7810</i> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>61</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth
Month <i>March</i> Day <i>6</i> Year <i>1939</i> | | 9. Birthplace (State or Foreign Country)
<i>MD</i> | | |
| To Be Completed by Funeral Director | 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town, or Location
<i>Baltimore</i> |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
<i>5611 Haddon Avenue</i> | | 10f. Zip Code
<i>21207</i> | | 10g. Citizen of What Country?
<i>USA</i> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>African American</i> | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>na</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Nursing Assistant</i> | | 16b. Kind of Business/Industry
<i>Hospital</i> |
| | 17. Father's Name (First, Middle, Last)
<i>James Gaylor</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Williamia Smith</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Given Gaylor (sister)</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5115 Gwynn Oak Ave. Baltimore, MD 21207</i> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>King Mead Park</i> | | 20c. Location - City or Town, State
<i>09-01-00 Randallstown, MD</i> |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
<i>Wylie Fried Home PA
638 N. Gilman Street BALTIMORE, MD 21217</i> | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Cardiovascular arrest</i>
Due to (or as a consequence of):
<i>b. Probable myocardial infarction; pulmonary embolism</i>
Due to (or as a consequence of):
<i>c. History of Transient Ischemic attack</i>
Due to (or as a consequence of):
<i>d. Hypertension; Renal insufficiency</i> | | | | Approximate interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Depression</i> | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | |
| | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Sofia M. Surich, M.D.</i> | | 29c. License number
<i>D0020567</i> |
| | 29d. Date signed (Month, Day, Year)
<i>08/29/2000</i> | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>SOPIA M. SURICH, M.D. 522 POLKMAN ST. BALTIMORE, MD 21217</i> | | | | |
| | 31. Date filed (Month, Day, Year)
<i>AUG 30 2000</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 27390

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CATHERINE SWANN | | | | 2. Date of Death
Month Aug. Day 28 Year 2000 | | 3. Time of Death
3:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
DULANEY VALLEY NURSING CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
212-30-4061 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov 10 1926 | |
| | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
DIETARY AIDE | | 16b. Kind of Business/Industry
MEDICAL CENTER | |
| | 17. Father's Name (First, Middle, Last)
DAVID WASHINGTON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMMA CUCHIMBER | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ANGELA SWANN - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3910 GARRISON BLVD BALTO., MD 21215 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS MEMORIAL PARK | | 20c. Location - City or Town, State
9-1-00 BALTO., MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
MARCH FUNERAL HOME WEST, INC.
4300 WABASH AVE. BALTO., MD 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. End stage renal disease
Due to (or as a consequence of):
b. Peripheral Vascular disease
Due to (or as a consequence of):
c. Coronary Artery disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
24 years
59 years
59 years | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
Aug 29 2000 | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| State Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Attending Physician | | 29c. License number
D53642 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
X DO 21215 3007 E Northern Parkway Baltimore 21218 | | | | 29d. Date signed (Month, Day, Year)
Aug 29 2000 | | | |
| | 31. Date (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
 | | | |

ORIGINAL

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Amended Item#19b perfhg787 9/8/2000 EW

Amended Items 319a 19b perINF G787 9/8/2000 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27391

| | | | | | | | | |
|---|---|---|--|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TILLIE SANDLER | | | | 2. Date of Death
Month Day Year
AUGUST 27, 2000 | | 3. Time of Death
10:11PM | |
| | 4a. Facility Name (If not institution, give street and number)
JEWISH CONVALESCENT & NURSING HOME | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-30-6702 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
FEB. 28, 1918 | | 9. Birthplace (State or Foreign Country)
POLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
7920 SCOTTS LEVEL ROAD | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| 17. Father's Name (First, Middle, Last)
HENOCHE | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ECKHAUS BRYNA SUCHOWOLSKI | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
LOIS BENSKY | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6411 Bay Club Dr. Ft. Lauderdale FL 33308 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HAPLATA | | 20c. Location - City or Town, State
ROSEDALE, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy
Due to (or as a consequence of):

b. Renal failure
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 MD | | | | 29c. License number
D51426 | | 29d. Date signed (Month, Day, Year)
August 28, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Elliot Rothschild 4000 Old Court Rd, Pikesville, MD 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27392

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louis A. Valenti SR. | | | | 2. Date of Death
Month August Day 26 Year 2000 | | | | 3. Time of Death
12:10am | | |
| | 4a. Facility Name (If not institution, give street and number)
Future Care Homewood | | | | 4b. City, Town, or Location of Death
Baltimore City | | | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
212-10-2574 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 7, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
1353 Andre Street | | | | 10f. Zip Code
21230 | | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Steel Worker | | | | 16b. Kind of Business/Industry
Beth Steel | | | | 17. Father's Name (First, Middle, Last)
Sebastian Valenti | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Musumeci | | | | 19a. Informant's Name/Relationship (Type, Print)
Louis A. Valenti Jr. Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1353 Andre Street, Baltimore Maryland 21230 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer Cemetery | | | | 20c. Location - City or Town, State
Baltimore Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Port Avenue Baltimore Maryland 21230 | | | | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Coronary artery Disease
Due to (or as a consequence of): | | |
| | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
End Stage renal disease, Diabetes | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
Aug 29 2000 | | | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
D. S. Saluja | | | |
| 29c. License number
D17537 | | | | 29d. Date signed (Month, Day, Year)
8-27-2000 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DARSHAN S. SALUJA MD 1600 W. MOUNT ROYAL AVE, BALTO MD 21217 | | | |
| 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
 | | | | State Registrar | | | |

1000
X

Chaffin

1501 East Ford

Company anding license

of different states

OR LAND

1961
D1523

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27393

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Andrew R. Walter Sr. | | | | 2. Date of Death
Month August Day 28 Year 2000 | | 3. Time of Death
9:33A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
219-26-8173 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 18 1936 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | |
| To Be Completed by Funeral Director | 10e. Street and Number
233 South Carolina Ave. | | | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1958 to 1961 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Police Officer | | 16b. Kind of Business/Industry
Baltimore City | |
| | 17. Father's Name (First, Middle, Last)
Frank J. Walter Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Mackay | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Brenda Claudette Walter Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
233 South Carolina Ave. Pasadena Md. 21122 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Cemetery | | 20c. Location - City or Town, State
Elkridge Md. | | 20d. Date
Aug. 31 2000 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensed
 | | | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore Maryland 21230 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEPSIS

Due to (or as a consequence of):
PNEUMONIA

Due to (or as a consequence of):
VENTRICULAR FIBRILLATION

Due to (or as a consequence of):
CHRONIC RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier

MD | | | | 29c. License number
D43977 | | 29d. Date signed (Month, Day, Year)
August 28 2000 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Agorka Odetunji, 301 Hospital Drive Glen Burnie, MD 21061 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 30 2000 | | | | 32. Registrar's Signature
 | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27394

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIE SNELLINGS - WINNET

2. Date of Death

AUG 14 2000

3. Time of Death

726 pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

233-98-6567

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 28, 1958

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7619 Coachlight Lane

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Racing Official

16b. Kind of Business/Industry

Horse Racing

17. Father's Name (First, Middle, Last)

Aubrey Snellings

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Graves

19a. Informant's Name/Relationship (Type, Print)

Cyd Boulmetis - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1205 Barclay Towers, Cherry Hill, N. J. 08034

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Washington Crm.

8/21/00

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Kim Schlang

22. Name and Address of Facility

Fleck Funeral Home

601 Sandy Spring Rd., Laurel, Md. 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause of each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

QUADRIPLÉGIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

26a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Francis Chuidian MD

29c. License number

042892

29d. Date signed (Month, Day, Year)

AUG 14 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS CHUIDIAN 10724 LITTLE PATIENT LANE #200 COLUMBIA MD 21046

State
Registrar

31. Date filed (Month, Day, Year)

AUG 30 2000

32. Registrar's Signature

Francis Chuidian

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27395

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|---|---|--|---|-------------------------------|---|-----------------------|----------------|-------------------------------|----------------|----------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Laurie Anderson | | | | 2. Date of Death
Month August Day 12 Year 00 | | 3. Time of Death
11:45pm | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
213-21-3599 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
12 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 10, 1987 | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2355 Tyrone Road | | 10f. Zip Code
21158 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry
Education | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Norman C. Anderson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Theodora McLean | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Theodora McLean/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2355 Tyrone Road Westminster, MD 21158 | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Branch Cemetery | | Date
8/16/2000 | | 20c. Location - City or Town, State
Westminster, MD | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Jeffrey N. Zumbun Funeral Home
6028 Sykesville Road Eldersburg, MD 21784 | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Enterobacter Sepsis</td> <td>Approximate Interval Between Onset and Death
3 days</td> </tr> <tr> <td>b. Neutropenia</td> <td>2 weeks</td> </tr> <tr> <td>c. Large Cell Lymphoma</td> <td>4 weeks</td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Enterobacter Sepsis | Approximate Interval Between Onset and Death
3 days | b. Neutropenia | 2 weeks | c. Large Cell Lymphoma | 4 weeks | d. _____ | |
| | Immediate Cause (Final disease or condition resulting in death) | a. Enterobacter Sepsis | Approximate Interval Between Onset and Death
3 days | | | | | | | | | | | | | | |
| b. Neutropenia | | 2 weeks | | | | | | | | | | | | | | | |
| c. Large Cell Lymphoma | | 4 weeks | | | | | | | | | | | | | | | |
| d. _____ | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Immunoglobulin deficiency, Congenital | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D0044627 | | 29d. Date signed (Month, Day, Year)
August 12, 00 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Englander, MD, University of Maryland Hosp. 22 S. Greene St. Balt. MD | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27396

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|---|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Maurice Bowman | | | | 2. Date of Death
Month Day Year
August 2 2000 | | | | 3. Time of Death
9:30am | | | |
| | 4a. Facility Name (If not institution, give street and number)
806 S. Main Street | | | | 4b. City, Town, or Location of Death
Mount Airy | | | | 4c. County of Death
Frederick | | | |
| Funeral
Director | 5. Social Security Number
218-30-9533 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov 29 1911 | | 9. Birthplace (State or Foreign Country)
Md | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
Frederick | | 10c. City, Town or Location
Mount Airy | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
806 S. Main Street | | | | 10f. Zip Code
21771 | | 10g. Citizen of What Country?
USA | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
farmer | | | | 16b. Kind of Business/Industry
agriculture | | | |
| | 17. Father's Name (First, Middle, Last)
Augustus L. Bowman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Elizabeth Gillis | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Violet Lawson Bowman (spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
806 S. Main St., Mt. Airy, MD 21771 | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation Serv | | Data
8-3-2000 | | 20c. Location - City or Town, State
Sykesville, Md | | | | | |
| | 21. Signature of Funeral Service Licensee
Paige Haight Herbert | | | | 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Renal Failure
Due to (or as a consequence of):
Head & Neck Carcinoma
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Head & Neck Carcinoma | | | | | | | | | | Approximate Interval Between Onset and Death
7 days
3 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Head & Neck Carcinoma | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
N/A | | 28b. Time of Injury
N/A M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
N/A | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | 29b. Signature and title of certifier
Paul F. Castellanos, MD Surgeon | | | | 29c. License number
D46288 | | 29d. Date signed (Month, Day, Year)
8/9/00 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul F. Castellanos, MD 16 S. Eutan St. Suite 500 Baltimore, MD 21201 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
Benita S. Sparks | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27397

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Catherine Barber

2. Date of Death

Month
August

Day

8

Year
2000

3. Time of Death

9:20 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

218-07-4917

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 28 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13701 Bottom Road

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

domestic

17. Father's Name (First, Middle, Last)

John Giza

18. Mother's Name (First, Middle, Maiden Surname)

Pelage Danielak

19a. Informant's Name/Relationship (Type, Print)

Kathleen Barber (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 Shadyside Rd., Baltimore, Md 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Barber Family Farm

Date

8-11-2000

20c. Location - City or Town, State

Mt. Airy, Md.

21. Signature of Funeral Service Licensee

Brian J. Hays

22. Name and Address of Facility

Haight Funeral Home & Chapel

P.O. Box 195 Sykesville, Md 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Vrosepis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Aortic Valve Replacement and

Coronary Bypass Graft

End stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Diosdado Irlandes MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital

Diosdado Irlandes 2401 W. Belvedere Ave. Baltimore, Md 21215

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Beverly B Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27398

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN BURDETT

2. Date of Death

AUGUST

Day

11

Year

2000

3. Time of Death

6:20 AM

4a. Facility Name (If not institution, give street and number)

11720 LOVEJOY ST.

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-36-8468

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 23, 1929

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11720 LOVEJOY ST.

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: KOREAN WAR

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CIVIL ENGINEER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ISADORE BURDETT

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA MALLINOFF

19a. Informant's Name/Relationship (Type, Print)

NORMA L. BURDETT

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11720 LOVEJOY ST, SILVER SPRING, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. LEBANON CEMETERY

Date

8/13/00

20c. Location - City or Town, State

ADELPHI, MD

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. TRANSITIONAL CELL CARCINOMA OF BLADDER

Due to (or as a consequence of):

b. WITH LIVER INVOLVEMENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COLON CANCER

NON HODGKINS LYMPHOMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda M. Burrell

29c. License number

D35996

29d. Date signed (Month, Day, Year)

8-11-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA M. BURRELL, MD, 2101 MEDICAL PARK, DR., #210 SILVER SPRING, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27399

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Henry Buck | | | | 2. Date of Death
Month August Day 16 Year 2000 | | 3. Time of Death
7:22 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Casey House | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
116-22-6601 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 22, 1912 | |
| | 9. Birthplace (State or Foreign Country)
England | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
407 Russell Avenue, # 812 | | 10f. Zip Code
20877 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nuclear Physicist | | 16b. Kind of Business/Industry
Federal Government | | 17. Father's Name (First, Middle, Last)
Henry G. Buck | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Anne Crooke | | 19a. Informant's Name/Relationship (Type, Print)
Carolyn F. Buck/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
407 Russell Avenue, # 812, Gaithersburg, MD. 20877 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Date
8/17/00 | | 20d. Location - City or Town, State
Alexandria, Virginia | | 21. Signature of Funeral Service Licensee
 | | |
| 22. Name and Address of Facility
DeVol Funeral Home | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
End Stage Alzheimers Disease | | 23b. Approximate Interval Between Onset and Death
years | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 23d. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23e. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year)
M | | 28b. Time of Injury
11:00 AM | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 15046 | | 29d. Date signed (Month, Day, Year)
August 16, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen J. Newman, M.D., 11500 Old Georgetown Road, Rockville, Maryland 20852 | | 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
 | | State Registrar | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27400

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAZEL E. BROOKER

2. Date of Death

Month

Day

Year

August 6 2000

3. Time of Death

2132

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-44-8484

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 18, 1906

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

2412 Second Street, N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

African American

Specify:

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Reproduction Technician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Roberta Shelton

19a. Informant's Name/Relationship (Type, Print)

Zenobia V. Brooker Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9304 Copernicus Drive, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

8/10/00

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Thomas D. Clyburn

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador S. Soto, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

August 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Soto, 3001 Hospital Drive, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend #1, 8/22/2000, BMW, Montg. Co.

00 27401

Physician
/Medical
Examiner1. Decedent's Name (First, Middle, Last)
Ann Frances Bresak
~~Ann Bresak~~2. Date of Death
Month Day Year
August 16, 20003. Time of Death
12:40pm

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

302-38-1294

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 21, 1942

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7016 Channel Village Court #T1

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Organic Chemist

16b. Kind of Business/Industry

Research & Development

17. Father's Name (First, Middle, Last)

Joseph Bresak

18. Mother's Name (First, Middle, Maiden Surname)

Ann Thomsic

19a. Informant's Name/Relationship (Type, Print)

Anne-Marie Seaborne (Pers. Rep.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Rock Creek Court, Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

8/23/00

20c. Location - City or Town, State

Lorain, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Staphylococcus Septicemia

Approximate Interval Between Onset and Death

2 days

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26743

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard B. Goldstein M.D.

205 Ridgely Ave
Annapolis, Md. 21401State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27402

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Helen Babcock

2. Date of Death

Month Day Year
August 16, 2000

3. Time of Death

4:00AM

4a. Facility Name (If not institution, give street and number)

Montgomery Village Care and Rehab.

4b. City, Town, or Location of Death

Montgomery Village

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

398-16-7448

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 10, 1906

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19301 Watkins Mill Road

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Food Preparation

17. Father's Name (First, Middle, Last)

Fred E. White

18. Mother's Name (First, Middle, Maiden Surname)

Helena M. Scharlau

19a. Informant's Name/Relationship (Type, Print)

David E. Olsen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20705 Crystal Hill Circle, Apt. J, Germantown, MD 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Montgomery Crematorium, Inc.

Date

August 18, 2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO1126

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue,
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Arteriosclerotic Cardiovascular Disease

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

04115

29d. Date signed (Month, Day, Year)

August 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, Maryland 20817-1664

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27403

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marilyn J. Barnett

2. Date of Death

Month Day Year
August 10, 2000

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

227-34-1170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 27, 1929

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

528 Bradford Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Graphic Designer

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

Hall Orr

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Macey

19a. Informant's Name/Relationship (Type, Print)

Thomas M. Barnett/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

528 Bradford Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Aug. 16, 2000

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonitis

Approximate Interval Between Onset and Death

2 days

Due to (or as a consequence of):

b. Acute Myelocytic Leukemia

1 month

Due to (or as a consequence of):

c. Myelofibrosis

3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D04602

29d. Date signed (Month, Day, Year)

August 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeremy V. Cooke, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Barnett, Marilyn 08/10/00 3AM.
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

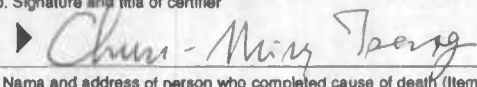
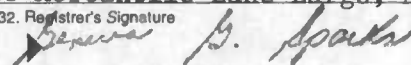
00 27404

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gilberto Bartens | | | | 2. Date of Death
Month Aug Day 11 Year 2000 | | 3. Time of Death
1:37 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
266-25-6694 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug 8, 1941 | | |
| | 9. Birthplace (State or Foreign Country)
Peru | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
10912 Glen Heaven Parkway | | 10f. Zip Code
20902 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Peruvian | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bus Driver | | 16b. Kind of Business/Industry
Transportation | | | | | |
| 17. Father's Name (First, Middle, Last)
Gilberto Bartens | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Consuelo Oliveira | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Judy Arauzo/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11102 Conti Place, Silver Spring, MD 20902 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven | | 20c. Date
8/14/00 | | 20d. Location - City or Town, State
Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring, MD 20901 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | a. Hypoxemia
Due to (or as a consequence of):
b. Lung Fibrosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 MD | | 29c. License number
D52043 | | 29d. Date signed (Month, Day, Year)
8/11/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chun-Ming Tseng MD 1221 Mercantile Lane Largo, MD 20774 | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27405

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dr. Dulal

Krishna

Basu

2. Date of Death

Aug. 14, 2000

3. Time of Death

17:38

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 10, 1932

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

India

10b. County

None

10c. City, Town or Location

New Delhi

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7176 B-10 Vasant Kunj

10f. Zip Code

110070

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Indian Government

17. Father's Name (First, Middle, Last)

Nitai Krishna Basu

18. Mother's Name (First, Middle, Maiden Surname)

Savitri Bala Dutta

19a. Informant's Name/Relationship (Type, Print)

Anand Basu - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7176 B-10, Vasant Kunj, New Delhi, India 110070

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

N. Virginia Crematory

Date

8/16/00

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Arlington Funeral Home
3901 N. Fairfax Dr., Arlington, VA 22203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

00053864

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Silva 9715 Medical Center Drive Rockville MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G786 8-31-00 WR.

Certificate of Death

00 27406

Reg. No.

| | | | | | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES ALLAN BELL, SR. | | | | 2. Date of Death
Month Day Year
AUGUST 08, 2000 | | | | 3. Time of Death
12:15 P.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY | | | | |
| Funeral
Director | 5. Social Security Number
215-84-2592 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
38 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 5, 1962 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
804 Amber Tree Court, #101 | | | | 10f. Zip Code
20878 | | | | 10g. Citizen of What Country?
United States | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Painter | | | | 16b. Kind of Business/Industry
Self-Employed | | | | | |
| 17. Father's Name (First, Middle, Last)
Earl Ferdinand Bell | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Parsons | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Angela Rae Bell, Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
804 Amber Tree Court, #101 Gaithersburg, MD 20878 | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | 20c. Location - City or Town, State
2000 Silver Spring, MD | | | | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 E. Deer Park Dr., Gaithersburg, MD 20877 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. HYDROMORPHONE INTOXICATION
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
8-8-00 | | 28b. Time of Injury
UNKNOWN | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
UNKNOWN | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: HOME | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
19319 CLUB HOUSE RD. APT. 303, GAITHERSBURG | | | | | | | | | |
| 29a. Certifier
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Stephen S. Radentz, M.D.</i> | | | | 29c. License number
O.C.M.E. | | | | 29d. Date signed (Month, Day, Year)
AUGUST 09, 2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27407

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>ETHEL BENJAMIN</i> | | | | 2. Date of Death
Month <i>8</i> Day <i>8</i> Year <i>2000</i> | | 3. Time of Death
<i>7:24 AM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>WASHINGTON ADVENTIST HOSPITAL</i> | | | | 4b. City, Town, or Location of Death
<i>TAKOMA PARK MD</i> | | 4c. County of Death
<i>MONTGOMERY</i> | |
| Funeral
Director | 5. Social Security Number
<i>086-05-2510</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
<i>94</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>7-18-1906</i> | 9. Birthplace (State or Foreign Country)
<i>NEW YORK</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>MONTGOMERY</i> | | 10c. City, Town or Location
<i>SILVER SPRING</i> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
<i>2505 MUSGROVE RD.</i> | | | | 10f. Zip Code
<i>20904</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>WHITE</i> | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>SECRETARY</i> | | 16b. Kind of Business/Industry
<i>SHOE MANUFACTURING</i> | | |
| 17. Father's Name (First, Middle, Last)
<i>NATHAN MOSKOWITZ</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>MARY SALPETER</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>JACQUELINE M. MORSE NIECE</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>KASHIWA-SHI, CHIBA-KEN 277-0065 JAPAN</i> | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>FERNCLIFF CEMETERY</i> | | 20c. Location - City or Town, State
<i>8/14/00 HARTSDALE, NY</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Ronald W. Revenburg</i> | | | | 22. Name and Address of Facility
<i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</i> | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Atherosclerotic Coronary Art. Disease</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>b. Due to (or as a consequence of):</i>
<i>c. Due to (or as a consequence of):</i>
<i>d. Due to (or as a consequence of):</i> | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Lawrence Simon</i> | | | | 29c. License number
<i>D36177</i> | | 29d. Date signed (Month, Day, Year)
<i>8-8-2000</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>LAWRENCE SIMON, WASHINGTON ADVENTIST HOSPITAL</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>AUG 14 2000</i> | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27408

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED GRADY BETTS

2. Date of Death

AUGUST 8, 2000

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

2205 Quinton Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-42-9583

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 25, 1930

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2205 Quinton Road

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Thomas Alvin Grady

18. Mother's Name (First, Middle, Maiden Surname)

Dovie Bass

19a. Informant's Name/Relationship (Type, Print)

Keter Betts Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2205 Quinton Road, Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Cemetery

Date

8/12/00

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Andie Thompson

22. Name and Address of Facility

McGuire Funeral Service, Inc.
7400 Georgia Ave. N.W., Washington, D.C. 2001223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Larry A. Oates MD

29c. License number

D41926

29d. Date signed (Month, Day, Year)

8-11-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Larry A. Oates, M.D. 10810 Connecticut Ave., Kensington, MD

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12/1/1914

12/1/1914

12/1/1914

12/1/1914

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27409

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joyce Beyzaei

2. Date of Death

Month 8 Day 12 Year 2000

3. Time of Death

1:02am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park, MD

4c. County of Death

Montgomery County

5. Social Security Number

010-38-7303

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 30, 1948

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

University Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4302 Claggett Road

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Mortgage Company

17. Father's Name (First, Middle, Last)

Vante Heikkila

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude LeVangie

19a. Informant's Name/Relationship (Type, Print)

George Beyzaei/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4302 Claggett Road, University Park, MD 20872

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/15/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Tracy A. Stuer

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phyllis E. Nicholson MD

29c. License number

D28429

29d. Date signed (Month, Day, Year)

8/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phyllis E. Nicholson, MD

Washington Adventist Hospital

7600 Carroll Ave

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27410

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANKLIN H. BLAIR JR. | | | | 2. Date of Death
Month Day Year
AUGUST 8, 2000 | | 3. Time of Death
10:30AM | |
| | 4a. Facility Name (If not institution, give street and number)
SOUTHERN MARYLAND HOSPITAL | | | | 4b. City, Town, or Location of Death
CLINTON | | 4c. County of Death
P.G. | |
| Funeral
Director | 5. Social Security Number
215-98-0530 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
34 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
MAY 5, 1966 | | 9. Birthplace (State or Foreign Country)
WASHINGTON, DC. |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
P.G. | | 10c. City, Town or Location
UPPER MARLBORO | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
12729 TOWN CENTER WAY | | | | 10f. Zip Code
20774 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 4 YEARS | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
ELECTRICAL ENGINEER | | 16b. Kind of Business/Industry
EDS | | |
| 17. Father's Name (First, Middle, Last)
FRANKLIN H. BLAIR SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
BETTY J. THOMPSON | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JULIETTE L. BLAIR (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12729 TOWN CENTER WAY, UPPER MARLBORO, MD. 20774 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematorium or other place)
LINCOLN CEMETERY | | Date
8/15/00 | | 20c. Location - City or Town, State
SUITLAND, MARYLAND | | |
| 21. Signature of Funeral Service Licensee
<i>Temple C. Parker</i> | | | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH STREET N.W. WASHINGTON, DC. 20011 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Basilar Artery Thrombosis of unknown Cause
Due to (or as a consequence of):
b. Brain stem infarction.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
48 hr
24 hr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Rointon Farahi M.D. | | | | | | |
| 29c. License number
D43446 | | 29d. Date signed (Month, Day, Year)
08/09/2000 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROINTAN FARAH-FAR MD 9801 Georgia Ave Suite 3-35 SILVER SPRING MD 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27411

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olive M. Bogley

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

1:05 pm

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-12-2739

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 22, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

401 Russell Avenue #211

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Theodore McIlwee

18. Mother's Name (First, Middle, Maiden Surname)

Alta Unknown

19a. Informant's Name/Relationship (Type, Print)

Dennis M. Bogley/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 Whittingham Drive Silver Spring, Maryland 20904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

August 17, 2000

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Birschbach Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous cell carcinoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease - Hypertension
Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

04115

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robert Birschbach M.D. 6320 Democracy Boulevard Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Robert A. Murphy
Bethesda-Chevy Chase
Maryland 2

M00332

Ans. 1/1/74

ard Beth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19a, 8/18/2000, JW, Mont. Co.

Certificate of Death

Reg. No.

00 27412

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Page Borchetta

2. Date of Death

Month Day Year
August 10, 2000

3. Time of Death

6:45am

4a. Facility Name (If not Institution, give street and number)

15305 Jones Lane

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

089-44-6865

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
Jan. 25, 1947

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15305 Jones Lane

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Marketing Consultant

16b. Kind of Business/Industry

Computer

17. Father's Name (First, Middle, Last)

Yesun Ting

18. Mother's Name (First, Middle, Maiden Surname)

Florence Hsieh

19a. Informant's Name (Relationship, Type, Print)

Frank Jones (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15305 Jones Lane Gaithersburg, Md. 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

Date

Aug. 14,
2000

20c. Location - City or Town, State

Greenwich, Ct.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Paraganglioma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D 43083

29d. Date signed (Month, Day, Year)

August 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George A. Sotos M.D. 9701 Medical Center Dr. #300 Rockville, Md. 20850

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Barbara B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27413

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HONOR BRODY BOTOS

2. Date of Death

Month Day Year
AUG 14, 2000

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

6600 KEN HILL ROAD

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

059-22-0190

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUN 3, 1929

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6600 KEN HILL ROAD

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College 4-4or 5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MAURICE BRODY

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print)

SHERYL L. RIVLIN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

421 ELM AVE, TOKOMA PARK, MARYLAND 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS

Date

AUG 16, 2000

20c. Location - City or Town, State

FALLS CHURCH, VA

21. Signature of Funeral Service Licensee

►

Vernon Simmons

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CACHEXIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC UTERINE CANCER

Due to (or as a consequence of):

10 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ENTEROVAGINAL FISTULA

VAGINAL BLEEDING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

►

Sandra J. Ginsberg, MD

29c. License number

19759

29d. Date signed (Month, Day, Year)

AUG 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDRA J. GINSBERG, MD, FACP 2021 K STREET, NW SUITE 516, WASHINGTON, DC 20006

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

Sandra J. Ginsberg

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27414

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn C. Barnes

2. Date of Death

Month
AugustDay
17Year
2000

3. Time of Death

0930

4a. Facility Name (If not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

090-22-1794

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 21, 1927

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

802 Travers Street

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Herbert

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Blous

19a. Informant's Name/Relationship (Type, Print)

Robert C. Barnes, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

802 Travers St., Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☒ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Rood Cemetery

Date

20c. Location - City or Town, State

Westbury, Long Island, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

808 High St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Advanced Dementia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure dis order

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 26388

29d. Date signed (Month, Day, Year)

August 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Friedman MD 302 Collins, Haverlock MD 21643

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

James M. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27415

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Pauline Muir Bozman | | | | 2. Date of Death
Month Day Year
Aug. 14, 2000 | | 3. Time of Death
14:35 | |
| 4a. Facility Name (If not institution, give street and number)
Manokin Manor Retirement Center | | | | 4b. City, Town, or Location of Death
Princess Anne | | 4c. County of Death
Somerset | |
| 5. Social Security Number
213-16-8236 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/23/1911 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD. | | 10b. County
Somerset | | 10c. City, Town or Location
Princess Anne | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
11974 Edgehill Terrace, # 300 | | 10f. Zip Code
21853 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) none | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Bank | | 17. Father's Name (First, Middle, Last)
J. Sylvester Muir | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Sadie Snyder | | 19a. Informant's Name/Relationship (Type, Print)
Tom Lewis/Nephew | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
708 Friar Tuck Lane, Salisbury, MD. 21804 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Peters U.M. Cemetery | | 20c. Date
8/17/00 | | 20d. Location - City or Town, State
Oriole, Maryland | | 21. Signature of Funeral Service Licensee
James L. Skuman M00295 | |
| 22. Name and Address of Facility
Hinman Funeral Home | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
ASCVD
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
DIABETES MELLITUS | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Dorothy C. Holzworth, M.D. | |
| 29c. License number
D06241 | | 29d. Date signed (Month, Day, Year)
8-16-00 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21263 | | 31. Date filed (Month, Day, Year)
AUG 17 2000 | |
| 32. Registrar's Signature
Bertha B. Sparks | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Items 3 & 25 per Phy. State of Maryland / Department of Health and Mental Hygiene
08/15/2000, Carroll County, wjl

Certificate of Death

Reg. No.

00 27416

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Catherine Elizabeth Close | | | | 2. Date of Death
Month Day Year
Aug 9 2000 | | 3. Time of Death
09:10a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Carroll County General Hospital | | | | 4b. City, Town, or Location of Death
Westminster | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
219-78-9840 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan 26 1915 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10. Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Westminster | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
22 W. George Street | | | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | |
| 17. Father's Name (First, Middle, Last)
George Bieker | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Bauerlein | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marie Close/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 W. George Street Westminster, MD 21157 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John Cemetery | | Date
8/12 | | 20c. Location - City or Town, State
Westminster, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Pritts Funeral Home and Chapel
412 Washington Rd Westminster, MD 21157 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia
Due to (or as a consequence of):
b. Cerebrovascular Accident
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 week
6 months |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Noninsulin diabetes mellitus | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Thomas K. Galvin M.D. | | 29c. License number
D21660 | | 29d. Date signed (Month, Day, Year)
8/9/2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1 Thomas K. Galvin M.D. 285 S. Street AVE. WESTMINSTER MD 21157 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Close, Catherine

0005/p'

9726117

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27417

Certificate of Death

Reg. No.

Amend Item#28c per FHG787 9/5/2000 EW

| | | | | | | | | |
|--|---|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LYNNE A. COPELAND | | | | 2. Date of Death
Month AUGUST Day 13 , Year 2000 | | 3. Time of Death
17:05 | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
212-90-4071 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
35 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 13, 1964 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Gaithersburg | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
9429 Royal Bonnet Terrace | | 10f. Zip Code
20877 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
School Bus Driver | | 16b. Kind of Business/Industry
Montg. Co. Schools | | 17. Father's Name (First, Middle, Last)
Clarence W. Copeland | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Esther A. Bright | | 19a. Informant's Name/Relationship (Type, Print)
Esther A. Copeland (Mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 5116, Laytonsville, MD 20882 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brooke Grove Cem. | | 20c. Date
8/18/00 | | 20d. Location - City or Town, State
Laytonsville, MD | | 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | |
| 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
3 DAYS | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 23c. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23d. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ACQUIRED IMMUNODEFICIENCY SYNDROME
PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY
CANDIDA ESOPHAGITIS | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>M.D.</i> | | 29c. License number
D35941 | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PURAN P. MATHUR 50 W. EDMONSTON DR #401 ROCKVILLE, MD 20852 | | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
<i>Anna B. Sparks</i> | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27418

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET V. COLEMAN

2. Date of Death

AUGUST 9, 2000

3. Time of Death

10:55 AM

4a. Facility Name (If not institution, give street and number)

8 Carver Road

4b. City, Town, or Location of Death

Cabin John

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-30-9195

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Cabin John

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8 Carver Road

10f. Zip Code

20818

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Clarence Gibbs

18. Mother's Name (First, Middle, Maiden Surname)

Essie Steiner

19a. Informant's Name/Relationship (Type, Print)

Bettyann Bullard (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Carver Road, Cabin John, MD 20818

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cem.

Date

8/14/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC ADENOCARCINOMA

4 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Victor M. Priego

29c. License number

023308

29d. Date signed (Month, Day, Year)

AUG. 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR. #625 BETHESDA, MD 20817

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Barbara B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27419

| | | | | | | | | |
|--|---|---|--|--|--|--|--|-----------------------------------|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANITA COHEN | | | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
11:40PM | |
| | 4a. Facility Name (If not institution, give street and number)
Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
568-16-4476 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
SEPT. 27, 1916 | |
| | 9. Birthplace (State or Foreign Country)
CALIFORNIA | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
GAITHERSBURG | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
THE GARDENS AT KENTLANDS 313 | | | | 10f. Zip Code
29878 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
VOCATIONAL COUNSELOR | | | 16b. Kind of Business/Industry
STATE OF CALIFORNIA | |
| 17. Father's Name (First, Middle, Last)
DAVID R. COHEN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
DELPHINE SILBERMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
BEVERLY BRAZIL (SISTER-IN-LAW) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16605 ROUNABOUT DR. GAITHERSBURG, MD. 20878 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GEORGETOWN MED SCH. 8/14/00 | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH STREET N.W. WASH, D.C. 20011 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of):
b. INTRACEREBRAL HEMORRHAGE
Due to (or as a consequence of):
c. CHRONIC ATRIAL FIBRILLATION
Due to (or as a consequence of):
d. HYPERTENSION | | | | | | | | |
| Approximate Interval Between Onset and Death
FIVE DAYS
FIVE DAYS
YEARS
FIVE DAYS | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D43358 | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GRACE SAGAYADAN, MD.
847-D QUINCE ORCHARD BLVD GAITHERSBURG MD 20878 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27420

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|--|--|--|--|--|---|----|--------------------------|--|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|--|----|---------------------|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|----|------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Roxie S. Cockrell | | | | 2. Date of Death
Month Day Year
AUGUST 11, 2000 | | | | 3. Time of Death
1355 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
MONTGOMERY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
OLNEY | | | | 4c. County of Death
MONTGOMERY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
244 12 0554 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV 14, 1903 | | 9. Birthplace (State or Foreign Country)
NORTH CAROLINA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number
3227 BEL PRE ROAD | | | | 10f. Zip Code
20906 | | | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOME MAKER | | | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
WILLIAM B. SKINNER | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELLA GREEN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MARGARET C LAKE (DAUGHTER) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13605 NORTH GATE DR. SILVER SPRING, MD 20906 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PINEVIEW CEMETERY | | Date
8-15-00 | | 20c. Location - City or Town, State
ROCKY MOUNT, NC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td colspan="7">Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death
2 yrs</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="7">Atrial Fibrillation</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="7">Pleural Effusion</td> <td></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Congestive Heart Failure | | | | | | | Approximate Interval Between Onset and Death
2 yrs | Due to (or as a consequence of): | | | | | | | | b. | Atrial Fibrillation | | | | | | | Due to (or as a consequence of): | | | | | | | | c. | Pleural Effusion | | | | | | | | Due to (or as a consequence of): | | | | | | | | | d. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Congestive Heart Failure | | | | | | | Approximate Interval Between Onset and Death
2 yrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | Atrial Fibrillation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | Pleural Effusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
chronic obstructive pulmonary disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
William J. Ninala | | | | 29c. License number
D45285 | | | | 29d. Date signed (Month, Day, Year)
August 12, 2000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WF Ninala, 344 University Blvd, #113, Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27421

| | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
STANLEY C. CLARK | | | | 2. Date of Death
Month AUG. Day 10, Year 2000 | | 3. Time of Death
8:10 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
FAIRLAND NURSING HOME | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
578-22-3797 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 21, 1925 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
8002 Piney Branch Rd. | | 10f. Zip Code
20910 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1942-
If Yes, Give Year or Dates: 1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | 16b. Kind of Business/Industry
E.H. Phifer Co. | | 17. Father's Name (First, Middle, Last)
Thomas Clark | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy M. Thomas | | 19a. Informant's Name/Relationship (Type, Print)
Betty A. Clark (Wife) | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8002 Piney Branch Rd. Silver Spring, Md. 20910 | | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chambers Crematory | | 20c. Location - City or Town, State
8/12/00 Riverdale Park, Md. | | 21. Signature of Funeral Service Licensee
Thomas S. Chambers #6710 | |
| 22. Name and Address of Facility
Chambers Funeral Homes, P.A. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Diabetes | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
136716 | | 29d. Date signed (Month, Day, Year)
Aug 10, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew K. ... | | 31. Date filed (Month, Day, Year)
AUG 14 2000 | |
| 32. Registrar's Signature
[Signature] | | 33. Date of Death (Month, Day, Year)
AUG 10, 2000 | | 34. Time of Death
8:10 AM | | 35. Place of Death
SILVER SPRING | | 36. County of Death
MONTGOMERY | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27422

| | | | | | | | | | | |
|--|---|--|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Martha Gray Claiborn | | | | | | 2. Date of Death
Month Day Year
August 12, 2000 | | 3. Time of Death
4:40 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Layhill Center | | | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
489-24-3198 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 79 | | 8. Date of Birth (Month, Day, Year)
July 26, 1921 | | 9. Birthplace (State or Foreign Country)
Missouri | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Olney | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
17321 Lafayette Drive | | | | 10f. Zip Code
20832 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | | 16b. Kind of Business/Industry
United States Government | | |
| | 17. Father's Name (First, Middle, Last)
Harvey G. Gray | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Frances Lay | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Harold G. Claiborn/ Husband | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17321 Lafayette Drive, Olney, Maryland 20832 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | Date
August 13, 2000 | | 20c. Location - City or Town, State
Bethesda, Maryland | |
| | 21. Signature of Funeral Service Licensee
 M00689 | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Pneumonia</u>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| State
Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 MD | | | | 29c. License number
D38262 | | | 29d. Date signed (Month, Day, Year)
August 12, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. A. MENDHIRATTA 2401 Research BLVD Suite 340 MD | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27423

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PING-LIAN HO CHU

2. Date of Death

Month Day Year
AUGUST 11, 2000

3. Time of Death

7:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Care & Rehab

4b. City, Town, or Location of Death

Rockville

4c. County of Death

MONTGOMERY

5. Social Security Number

154-72-0823

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 21, 1916

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

11609 Letterman Way

10f. Zip Code

20878

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

C.H. HO

18. Mother's Name (First, Middle, Maiden Surname)

Ku Shih

19a. Informant's Name/Relationship (Type, Print)

Tsi Chu (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11609 Letterman Way, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan F/Serv

Date

8/14/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC LYMPHOCYTIC LEUKEMIA ENDSTAGE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PHYSICIAN

29c. License number

D0054566

29d. Date signed (Month, Day, Year)

8/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. BHOCAVILLI, 8609 2ND AVE., APT #404B, SILVERSPRING MD 20910.

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27424

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alfanso Cerdan | | | | 2. Date of Death
Month Day Year
Aug 13 2000 | | 3. Time of Death
9:21 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
227-69-3546 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
52 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb 22, 1948 | | 9. Birthplace (State or Foreign Country)
Peru |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Takoma Park | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
8604 Flower Avenue Apt. 101 | | | | 10f. Zip Code
20912 | | 10g. Citizen of What Country?
Peru | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Peru | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef | | | 16b. Kind of Business/Industry
Restaurant | |
| 17. Father's Name (First, Middle, Last)
Eloyn Cerdan | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Magdalena Abanto | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Celestina Cerdan/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8604 Flower Ave. Apt. 101, Takoma Park, MD 20912 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate Of Heaven | | Date
8/18/00 | | 20c. Location - City or Town, State
Silver Spring, MD | | |
| 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Respiratory Failure
Due to (or as a consequence of):
Interstitial lung disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Renal failure | | | | | | | | Approximate Interval Between Onset and Death
days
Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] MD | | | | 29c. License number
D 53411 | | 29d. Date signed (Month, Day, Year)
August 14 th 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JC Shesani MD 3060 mitchellville Rd # 103 Bowie MD 20716 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27425

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph Lawrence Carroll | | | | 2. Date of Death
Month August Day 15 Year 2000 | | 3. Time of Death
11:28A. | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
219-90-8226 | 6. Sex
MALE <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
34 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 13, 1966 | 9. Birthplace (State or Foreign Country)
Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
Maryland | 10b. County
Montgomery | 10c. City, Town or Location
Silver Spring | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
14005 Blazer Lane | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
helper | | 16b. Kind of Business/Industry
private | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Carroll | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jo Ann Leydorf | | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
JoAnn Carroll (Mother) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8613 34th Avenue College Park, Maryland 20740 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery | | Date
8/18/2000 | | 20c. Location - City or Town, State
Burtonsville, Maryland | |
| | 21. Signature of Funeral Service Licensee
Donald V. Borgwardt | | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
hours |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebral Palsy | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Medical Certification: To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Deepak Cuddapah, MD | | 29c. License number
D0051863 | | 29d. Date signed (Month, Day, Year)
August 18, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deepak Cuddapah, M.D. 3905 National Drive, #220 Burtonsville, Maryland 20866 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 18 2000 | | 32. Registrar's Signature
Benita B. Sparks | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27426

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VERA BEATRICE CANTY | | 2. Date of Death
Month Day Year
AUG. 14, 2000 | | 3. Time of Death
5:10 AM |
| | 4e. Facility Name (If not institution, give street and number)
MARINER HEALTH | | 4b. City, Town, or Location of Death
KENSINGTON | | 4c. County of Death
MONTGOMERY |
| Funeral
Director | 5. Social Security Number
240-38-0446 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 Yrs. | 8. Date of Birth (Month, Day, Year)
JAN. 26, 1930 | 9. Birthplace (State or Foreign Country)
N. CAROLINA |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | 10b. County
MONTGOMERY | 10c. City, Town or Location
KENSINGTON | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number
10231 CARROLL PL. | | 10f. Zip Code
20895 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK |
| | 17. Father's Name (First, Middle, Last)
ROLAND MATTHEWS | | 18. Mother's Name (First, Middle, Maiden Surname)
HATTIE HARRING | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MARIANNE WYBLE/FRIEND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7035 NATELLI WOODS LA., BETHESDA, MD. 20817 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | 20c. Location - City or Town, State
8/19/00 LANDOVER, MD. |
| | 21. Signature of Funeral Service Licensee
W. W. Chambers MO0091 | | 22. Name and Address of Facility
CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic coronary vascular disease years
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Jeanne P. Asher MD
29c. License number
D34032
29d. Date signed (Month, Day, Year)
8/14/00 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JEANNE P. ASHER MD 3720 FARRAGUT AVE KENSINGTON MD 20895 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
B. Sparks | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27427

Amend #3&26, 8/17/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|--|---|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Robert G Crawford | | | | 2. Date of Death
Month Day Year
August 10, 2000 | | 3. Time of Death
21:32 | |
| | 4a. Facility Name (If not institution, give street and number)
3205 Hewitt Avenue, #103 | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
212-24-7010 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
72 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sep 21, 1927 | | 9. Birthplace (State or Foreign Country)
WV |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Wheaton | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3205 Hewitt Avenue, #103 | | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Baker | | | 16b. Kind of Business/Industry
Food Industry | |
| 17. Father's Name (First, Middle, Last)
Russell C. Crawford | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edith H. Moore | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mitchell R. Crawford/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4132 Danube Court, Olney, MD, 20832 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
8/16/00 Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee
Tracy A. Shivers | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W
Silver Spring MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction
Due to (or as a consequence of):
Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
1 year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Dilated Cardiomyopathy

Peripheral Vascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Daniel J. Goldberg MD | | | | 29c. License number
021334 | | 29d. Date signed (Month, Day, Year)
August 11, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel J. Goldberg 6116 Executive Blvd Rockville, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
Debra B. Sparks | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27428

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLOYD Q. CROCKETT

2. Date of Death

Month Day Year
Aug. 13, 2000

3. Time of Death

11:52 PM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE, SALISBURY CENTER

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

228-24-0996

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 16, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26751 John Nelson Lane

10f. Zip Code

21817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

John W. Crockett

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Ann Sparrow

19a. Informant's Name/Relationship (Type, Print)

Lionel E. Lawson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9848 Carey Road - Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunnyridge Memorial Park

Date

8/16/00

20c. Location - City or Town, State

Crisfield, MD

21. Signature of Funeral Service Licensee

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Atkins, M.D.

29c. License number

D39813

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

FLOYD Q. CROCKETT
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27429

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) CUNG THI DUONG
2. Date of Death Month Day Year August 8, 2000
3. Time of Death 9:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) Montgomery Village Care & Rehabilitation
4b. City, Town, or Location of Death Montgomery Village
4c. County of Death Montgomery

5. Social Security Number 213-13-3145
6. Sex ☐ M ☒ F
7. Age (In yrs. last birthday) 97 Yrs.
8. Date of Birth (Month, Day, Year) Jan 1, 1903
9. Birthplace (State or Foreign Country) Viet Nam

Usual Residence of Decedent

10a. State Maryland
10b. County Montgomery
10c. City, Town or Location Gaithersburg
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 100 Duvall Lane, #102
10f. Zip Code 20877
10g. Citizen of What Country? United States

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trader
16b. Kind of Business/Industry Retail

17. Father's Name (First, Middle, Last) Unknown
18. Mother's Name (First, Middle, Maiden Surname) Unknown

19a. Informant's Name/Relationship (Type, Print) Xa Nguyen, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13204 Ewood Lane, Silver Spring, MD 20906

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory
Date Aug 13, 2000
20c. Location - City or Town, State Alexandria, Virginia

21. Signature of Funeral Service Licensee
22. Name and Address of Facility DeVol Funeral Home
10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA
Due to (or as a consequence of):
b. CACHEXIA
Due to (or as a consequence of):
c. RHEUMATOID ARTHRITIS
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Approximate Interval Between Onset and Death 4 DAYS
3 MONTHS
5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23b. Did tobacco use contribute to the cause of death?
☐ Yes ☒ No ☐ Probably ☐ Unknown
24a. Was an autopsy performed? ☐ Yes ☒ No
24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No
26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? ☐ Yes ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number D33443
29d. Date signed (Month, Day, Year) August 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Pollack, M.D., 809 Viers Mill Road, Rockville, Maryland 20850

31. Date filed (Month, Day, Year) AUG 15 2000
32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 27430

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|----------------------------------|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas Andrew Driessen | | | | 2. Date of Death
Month Day Year
Aug 13 2000 | | 3. Time of Death
1:35 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
395-10-9800 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr 9, 1917 | | |
| | 9. Birthplace (State or Foreign Country)
Wisconsin | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
3509 Fiske Terrace | | | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
5+ | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineer | | | 16b. Kind of Business/Industry
Civil | | | |
| 17. Father's Name (First, Middle, Last)
Cornelius Driessen | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Regina Clarke | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Iva Driessen/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3509 Fiske Terrace, Silver Spring, MD 20906 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Date
8/15/00 | | 20c. Location - City or Town, State
Alexandria, VA | | |
| 21. Signature of Funeral Service Licensee
Tracy A. Stuver | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring, MD 20901 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. BILATERAL PNEUMONIA
Due to (or as a consequence of):</p> <p>b. PARKINSON'S DISEASE
Due to (or as a consequence of):</p> <p>c. MULTIPLE CEREBROVASCULAR ACCIDENTS
Due to (or as a consequence of):</p> <p>d. CORONARY ARTERY DISEASE</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>ONE WEEK</p> </div> </div> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier
Jedappully | | | | 29c. License number
D 3798394 | | | 29d. Date signed (Month, Day, Year)
August 13, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHNNY EDAPPULLY, 3411 OLANWOOD CT #106, OLNEY, MD-20832 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | 32. Registrar's Signature
B. Sparks | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner
 Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27431

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Rodney Lamar Dickerson, Jr. | | | | 2. Date of Death
Month Day Year
AUGUST 13 2000 | | 3. Time of Death
18:35 PM | |
| | 4a. Facility Name (If not institution, give street and number)
LAUREL REGIONAL HOSPITAL | | | | 4b. City, Town, or Location of Death
LAUREL | | 4c. County of Death
PRINCE GEORGE'S | |
| Funeral
Director | 5. Social Security Number
435-95-3509 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
3 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 12, 1997 | |
| | 9. Birthplace (State or Foreign Country)
Ruston, LA. | | 10a. State
LA | | 10b. County
Winn Parish | | 10c. City, Town or Location
Winnfield | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
1704 Front Street | | | |
| | 10f. Zip Code
71483 | | | | 10g. Citizen of What Country?
USA | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
None | | 16b. Kind of Business/Industry
None | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Rodney Lamar Dickerson, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LaToya Nicole Walker | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
LaToya N. Walker / Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1704 Front Street. Winnfield, LA. 71483 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Ridge B.C. Cemetery | | 20c. Date
8/19/00 | | 20d. Location - City or Town, State
Winnfield, LA. | |
| | 21. Signature of Funeral Service Licensee
<i>Steven E. Laddell</i> | | 22. Name and Address of Facility
Capital Funeral Service
7211 Falls Church, VA. 22046 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Multiple blunt force injuries</i>
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
8-13-2000 | | 28b. Time of Injury
unknown | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
subject struck with blunt object | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3445 Andrew Court
Anne Arundel county, Maryland | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier
<i>Stephen S. Radentz, M.D.</i> | |
| | 29c. License number
O.C.M.E. | | | | | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | 31. Date filed (Month, Day, Year)
AUG 18 2000 | |
| | 32. Registrar's Signature
<i>Beverly B. Sparks</i> | | | | | | 33. Registrar's Name
Beverly B. Sparks | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27432

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret May Dove | | | | 2. Date of Death
Month Day Year
August 10, 2000 | | | | 3. Time of Death
1:05pm | |
| | 4a. Facility Name (If not Institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
217-32-8279 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 23, 1921 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | |
| | Usual Residence of Decedent | | | | 10a. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Damascus | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
26209 Johnson Drive | | | | 10f. Zip Code
20872 | |
| | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | | 17. Father's Name (First, Middle, Last)
Roy Etter | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Youse | | | | 19a. Informant's Name/Relationship (Type, Print)
Harold Phelps (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2524 Colonial Rd. Accokeek, Md. 20607 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park | | | | 20c. Location - City or Town, State
Rockville, Md. | |
| | 21. Signature of Funeral Service Licensee
Curtis E. Day | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Sudden Death
Due to (or as a consequence of):
b. Pulmonary Embolism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
Dr. Frank Listello M.D. | | | | 29c. License number
00027330 | | | | 29d. Date signed (Month, Day, Year)
August 10, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Frank Listello M.D. 9901 Medical Center Dr. Rockville, Md. 20850 | | | | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
Benita B. Sparks | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27433

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TESSIE LILA DOSIK

2. Date of Death
Month Day Year
AUGUST 16, 20003. Time of Death
1:00 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director5. Social Security Number
577-24-95056. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
78 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
JULY 9, 19229. Birthplace (State or Foreign
Country)
RUSSIA

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3005 SOUTH LEISURE WORLD BLVD. #303

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ABRAHAM BEGUN

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE FRISCHMAN

19a. Informant's Name/Relationship (Type, Print)

SANFORD DOSIK/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3005 S. LEISURE WORLD BLVD #303, SILVER SPRING, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 18, 2000 FALLS CHURCH, VIRGINIA

Date
AUGUST

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Vernon Simmons

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEPTICEMIA

Due to (or as a consequence of):

b. URINARY TRACT INFECTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

HOURS

2 WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONISM, DEMENTIA

INCONTINENCE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Steven Lipson MD

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

08/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN LIPSON 6121 MONTROBE ROAD, ROCKVILLE

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9

1950

1950

1950

1950

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State of Maryland / Department of Health and Mental Hygiene 00 27434

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEWIS A. DICKINSON | | | | 2. Date of Death
Month Day Year
AUGUST 12, 2000 | | | | 3. Time of Death
8:55AM | |
| | 4a. Facility Name (If not institution, give street and number)
MANOR CARE OF SILVER SPRING | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
579-22-0343 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 2, 1910 | | 9. Birthplace (State or Foreign Country)
WASHINGTON, DC | |
| | 10a. State
MARYLAND | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
SILVER SPRING | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3112 GRACEFIELD ROAD APT. 202 | | 10f. Zip Code
20904 | | | | 10g. Citizen of What Country?
UNITED STATES | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
Collega (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PURCHASING AGENT | | | | 16b. Kind of Business/Industry
FEDERAL GOVERNMENT | | | | |
| 17. Father's Name (First, Middle, Last)
ALBERT DICKINSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JESSIE DAVIS | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MILDRED DICKINSON/SPOUSE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3112 GRACEFIELD ROAD APT. 202 SILVER SPRING, MD 20904 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GEORGE WASHINGTON CEM. | | 20c. Date
8/15/00 | | 20d. Location - City or Town, State
ADELPHI, MD | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 | | | | | | |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. CARDIOPULMONARY ARREST
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
d. | | | | | | Approximate Interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
 | | | | | | | | |
| 29c. License number
D52261 | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALAN SEGAL, MD 1299 LAMBERTON DRIVE SILVER SPRING, MD 20904 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | | | |

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27435

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUE M. DENNIS

2. Date of Death

Month Day Year
August 12, 2000

3. Time of Death

5:30am

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-56-3253

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 9, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

301 Russell Ave.

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Edwin Marburger

18. Mother's Name (First, Middle, Maiden Surname)

Emma Edith Alton

19a. Informant's Name/Relationship (Type, Print)

Charles R. Dennis III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

275 Cape St. John Rd. Annapolis, Md. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft Lincoln Cemetery

Date

Aug. 15
2000

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ellen M. Pinholt MD

29c. License number

D51615

29d. Date signed (Month, Day, Year)

August 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ellen Pinholt M.D. 5530 Wisconsin Ave. Chevy Chase, Md. 20815 Suite#1045

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Beverly B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27436

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Thomas Datri

2. Date of Death

Month Day Year
AUGUST 11, 2000

3. Time of Death

1730 PM

4a. Facility Name (If not institution, give street and number)

18502 SPLIT ROCK LANE

4b. City, Town, or Location of Death

GERMANTOWN

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

201-50-6118

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 19, 1959

9. Birthplace (State or Foreign Country)

Penna.

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

18502 Split Rock Lane

10f. Zip Code

20874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self employed teacher

16b. Kind of Business/Industry

highschool

17. Father's Name (First, Middle, Last)

Frank Datri

18. Mother's Name (First, Middle, Maiden Surname)

Esther Summers

19a. Informant's Name/Relationship (Type, Print)

Frank Datri/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Fifth Avenue New Kensington, Pa 15068

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 8/13/00 Alexandria, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

Philip D. Rinaldi Funeral Service
11818 New Hampshire Ave. Silver Spring, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Contact Shotgun Wound of Head*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month/Day/Year)
Found 8-11-00

28b. Time of Injury

Found 1730 P

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

self inflicted shotgun wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

field

28f. Location (Street and Number or Rural Route Number, City or Town, State)

18502 Split Rock Lane Germantown, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis Chuteau

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chuteau

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27437

| | | | | | | | | | | |
|-------------------------------------|---|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patsy Ann Darcey | | | | 2. Date of Death
Month Day Year
AUGUST 13 2000 | | | | 3. Time of Death
11:20 AM | |
| | 4a. Facility Name (If not institution, give street and number)
542 COLLEGE PARKWAY | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
245-44-3254 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
Dec 29, 1933 | | 9. Birthplace (State or Foreign Country)
NC | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Rockville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
542 College Parkway | | 10f. Zip Code
20850 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Education | | 17. Father's Name (First, Middle, Last)
Walter Henry Bivens | | 18. Mother's Name (First, Middle, Maiden Surname)
Sallie Frances Winfree | | 19a. Informant's Name/Relationship (Type, Print)
Sue Darcey / Daughter | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3918 Oglethorpe St, Hyattsville, MD 20782 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Data
Aug 16 2000 | | 20c. Location - City or Town, State
Beltsville, MD | |
| | 21. Signature of Funeral Service Licensee
Beryl L. Helms | | 22. Name and Address of Facility
Rapp Funeral & Cremation Services
933 Gist Avenue Silver Spring, MD | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
AM | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Mary G. Ripple, M.D. | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
B. Sparks | | State Registrar | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend #10e, 8/17/2000, BMW, Montg. Co.

Reg. No. 00 27438

| | | | | | | | | | |
|---|---|---|--|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LASHONN R. EDELIN | | | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
5:08AM | | |
| | 4a. Facility Name (If not institution, give street and number)
5403 VIRGINIA COURT | | | | 4b. City, Town, or Location of Death
OXON HILL | | 4c. County of Death
P.G. | | |
| Funeral
Director | 5. Social Security Number
381-12-8241 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
36 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 21, 1964 | | |
| | 9. Birthplace (State or Foreign Country)
WASH., D.C. | | 10a. State
MD. | | 10b. County
P.G. | | 10c. City, Town or Location
OXON HILL | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
5403 Virginia Court
815 MAURY AVENUE | | 10f. Zip Code
20745 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
2 YEARS | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ADMINISTRATIVE ASST. | | 16b. Kind of Business/Industry
FEDERAL GOVERNMENT | | | | | |
| 17. Father's Name (First, Middle, Last)
ISAIAH RUFFIN JR. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
YVONNE LINDSAY | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
ANTHONY EDELIN (HUSBAND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
815 MAURY AVENUE, OXON HILL, MD. 20745 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
FT. LINCOLN CEMETERY | | Date
8/18/2000 | | 20c. Location - City or Town, State
BLADENSBURG, MD. | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
3821 14TH STREET N.W.
WASHINGTON, D.C. 20011 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>OSTEOSARCOMA (METASTATIC)</u>
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
yrs | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of Certifier
 | | 29c. License number
D19431 | | 29d. Date signed (Month, Day, Year)
8/16/00 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frank A. Reynolds, 11704 Livingston Rd #203 FT. Washington MD 20744 | | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27439

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DAVID LAVERNE EBELING

2. Date of Death

Month Day Year
August 16 2000

3. Time of Death

0046

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

218-40-9844

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 17 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

East New Market

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5726 Choptank Drive

10f. Zip Code

21631

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

postal clerk

16b. Kind of Business/Industry

U.S. Postal service

17. Father's Name (First, Middle, Last)

Herman Laverne Ebeling

18. Mother's Name (First, Middle, Maiden Surname)

Angeline Leatherwood

19a. Informant's Name/Relationship (Type, Print)

Brenda K. Ebeling-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5726 Choptank Drive, East New Market MD 21631

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

East New Market Cemetery

Date

8-19-00

20c. Location - City or Town, State

East New Market Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thomas Funeral Home PA

700 Locust St. Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Massive Hemoptysis
Due to (or as a consequence of):

30 min.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Carcinoma of lung
Due to (or as a consequence of):

3 yrs.

c. Carcinoma of lung - Pneumothorax
Due to (or as a consequence of):

6 yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0050799

29d. Date signed (Month, Day, Year)

8/18/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SHIRIN MOHAMMAD

302 Collins Ave., Hurlock, MD 21643

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Study of ...

007281 302

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Michael Fowler

2. Date of Death

Month Day Year
August 4, 2000

3. Time of Death

9:10P.

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-56-5105

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 30, 1942

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1XX Yes 2□ No

10e. Street and Number

7706 West Park Drive

10f. Zip Code

20783

10g. Citizen of What Country?

United States

11. Marital Status

1X Never Married 2□ Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1□ Yes 2XX No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2XX No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Real Estate Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Larry D. Fowler

18. Mother's Name (First, Middle, Maiden Surname)

Mary Margaret Battinieri

19a. Informant's Name/Relationship (Type, Print)

Lorraine F. Berry (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3904 Forreston Road Beltsville, Maryland 20705

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

George Washington Cemetery 8/7/2000 Adelphi, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Acute Alcoholic Hepatitis

Approximate
Interval Between
Onset and Death

weeks

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy
performed?

1□ Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1□ Yes 2XX No

25. Was case referred to medical
examiner?

1□ Yes 2X No

Hospital:

1□ Inpatient 2□ ER/Outpatient 3□ DOA

Other:

4□ Nursing Home 5□ Residence 8X Other (Specify) hospice

27. Manner of Death

1X Natural 5□ Pending
investigation
2□ Accident 6□ Could not be
determined
3□ Suicide
4□ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark S. Godec

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

August 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Godec, M.D. Casey House 6001 Muncaster Mill Rd. Rockville, Maryland 20855

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27441

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Joseph Fleming Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

6:10 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-44-7697

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 9, 1932

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9905 Markham Street

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 52-5513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Reprocessor

16b. Kind of Business/Industry

HUD

17. Father's Name (First, Middle, Last)

Edward Joseph Fleming

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Marie Harbers

19a. Informant's Name/Relationship (Type, Print)

Rachel Ann Fleming/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9905 Markham Street, Silver Spring, MD 20901

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/16/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Will T Bl

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Non Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Frederick G. Barr MD

29c. License number

D22775

29d. Date signed (Month, Day, Year)

8/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr MD 2730 University Blvd. W. #400, Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27442

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
YETTA FISHMAN | | | | | 2. Date of Death
Month Day Year
AUGUST 14, 2000 | | 3. Time of Death
2:15 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
CASEY HOUSE | | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | | | |
| Funeral
Director | 5. Social Security Number
107.28.7302 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
09.18.1911 | | 9. Birthplace (State or Foreign Country)
NEW YORK | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
ROCKVILLE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
6111 MONTROSE ROAD | | | | 10f. Zip Code
20852 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BOOKKEEPER | | | 16b. Kind of Business/Industry
CPA | | | | |
| 17. Father's Name (First, Middle, Last)
SAMUEL BRENNER | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FANNIE LANGER | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MICHAEL B. FISHMAN/SON | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1529 BLUE MAADOW ROAD, POTOMAC, MARYLAND 20854 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
KING DAVID MEMORIAL GDNS | | 20c. Location - City or Town, State
16, 2000 FALLS CHURCH, VA | | | | | | |
| 21. Signature of Funeral Service Licensee
Donald C. Stettin | | | | | 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. MITRAL VALVE INSUFFICIENCY
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
2 YEARS
8 YEARS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PULMONARY HYPERTENSION
DIABETES MELLITUS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
E. P. Libre MD | | | | | | | | | |
| 29c. License number
D09470 | | 29d. Date signed (Month, Day, Year)
AUGUST 14, 2000 | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. EUGENE P. LIBRE, M.D., 10400 CONNECTICUT AVE, KENSINGTON, MARYLAND 20895 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
B. Sparks | | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27443

| | | | | | | | | | |
|---|---|---|---|--|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Lenore B. Gill</u> | | | | 2. Date of Death
Month <u>Aug</u> Day <u>17</u> Year <u>2000</u> | | 3. Time of Death
<u>6:10 am</u> | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>FAIRHAVEN</u> | | | | 4b. City, Town, or Location of Death
<u>Sykesville</u> | | 4c. County of Death
<u>Carroll</u> | | |
| Funeral
Director | 5. Social Security Number
<u>214-40-5626</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>95</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month <u>Aug</u> Day <u>16</u> Year <u>2005</u> | | |
| | 9. Birthplace (State or Foreign Country)
<u>Md</u> | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | |
| | 10a. State
<u>Md</u> | | 10b. County
<u>Carroll</u> | | 10c. City, Town or Location
<u>Sykesville</u> | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<u>7200 Third Avenue</u> | | | | 10f. Zip Code
<u>21784</u> | | 10g. Citizen of What Country?
<u>USA</u> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>white</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>executive secretary</u> | | 16b. Kind of Business/Industry
<u>State of Maryland</u> | | |
| | 17. Father's Name (First, Middle, Last)
<u>Mr. Baldwin</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Lenore Woelper</u> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Carolyn Gill Morrison (daughter)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6044 East Rose Circle Dr., Phoenix, AZ 85018</u> | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>All County Cremation</u> | | Date
<u>8-17-2000</u> | | 20c. Location - City or Town, State
<u>Sykesville, Md</u> | | |
| | 21. Signature of Funeral Service Licensee
<u>Brian d. Haight</u> | | | | 22. Name and Address of Facility
<u>Haight Funeral Home & Chapel</u>
<u>P.O. Box 195, Sykesville, Md. 21784</u> | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<u>a. Congestive Heart Failure</u>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

<u>b.</u> Due to (or as a consequence of):

<u>c.</u> Due to (or as a consequence of):

<u>d.</u> | | | | | | | | Approximate Interval Between Onset and Death
<u>months</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Diabetes Mellitus (Type II)</u>
<u>Renal Failure</u> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<u>Ernestine Wright, MD</u> | | 29c. License number
<u>D52740</u> | | 29d. Date signed (Month, Day, Year)
<u>8/17/00</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<u>Ernestine Wright, Fairhaven 7200 Third Avenue Sykesville MD 21784</u> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>AUG 17 2000</u> | | 32. Registrar's Signature
<u>B. Sparks</u> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27444

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT D. GORGAS

2. Date of Death

Month Day Year
AUG. 12, 2000

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

CARROLL LUTHERAN VILLAGE HEALTH CARE

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

705-05-0133

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/23/1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

233 ST. MARK WAY

10f. Zip Code

21158

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

CIVIL ENGINEER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

HERBERT F. GORGAS

18. Mother's Name (First, Middle, Maiden Surname)

ROSALIE HOFFMAN

19a. Informant's Name/Relationship (Type, Print)

STANLEY SPEAKMAN -NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 BELMORE RD., LUTHERVILLE, MD. 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METRO CREMATORY

Date

8/14/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic squamous cell carcinoma

Approximate
Interval Between
Onset and Death

6 months

Due to (or as a consequence of):

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D17040

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard G. Lanham, M.D. 215 Washington Heights Med'l Ctr, Westminster,

MD 21157

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27445

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY THERESA GARNER

2. Date of Death

Month Day Year
AUGUST 15, 2000

3. Time of Death

3:18 AM

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

213-14-0880

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/16/1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

365 PLEASANTON RD. #21

10f. Zip Code

21157

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME MAKING

17. Father's Name (First, Middle, Last)

WILLIAM FRAUNHOLTZ

18. Mother's Name (First, Middle, Maiden Surname)

MARIE BROOKHART

19a. Informant's Name/Relationship (Type, Print)

MARY L. GILL -DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3509 OXWED CT., WESTMINSTER, MD. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LORRAINE PARK CEM. 8/18/00

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Intra-Abdominal Aortic ANEURYSM
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 51245

29d. Date signed (Month, Day, Year)

AUGUST 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAJID SHARIF CARROLL CNTY GENERAL HOSPITAL. WESTMINSTER-MD. 21157

State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

MAY THERESA GARNER
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27446

| | | | | | | | | | | |
|---|---|--|--|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS G. GOBBETT SR. | | | | 2. Date of Death
Month Day Year
AUGUST 15 2000 | | | | 3. Time of Death
12:32 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death
BETHESDA | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
578-24-7352 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 8, 1926 | | 9. Birthplace (State or Foreign Country)
WASH. D.C. | |
| | Usual Residence of Decedent | | | | 10a. State
MD. | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
RIVERDALE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
6321 RIVERDALE, RD. | | | | 10f. Zip Code
20737 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1944-1946 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HANDYMAN | | | | 16b. Kind of Business/Industry
SELF EMPLOYED | | | | 17. Father's Name (First, Middle, Last)
JAMES GOBBETT | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
ALICE KING | | | | 19a. Informant's Name/Relationship (Type, Print)
LINDA HOLLAR/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8718 CREST RD., SEVERN, MD. 21144 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHAMBERS CREMATORY | | | | 20c. Date
8/21/00 | |
| | 20d. Location - City or Town, State
RIVERDALE, MD. | | | | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Electrocution</u>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year)
8-15-00 | |
| 28b. Time of Injury
1200 PM | | | | 28c. Injury at Work?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred
working on a dryer | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
building | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
6042 Loganwood Dr Bethesda, Md | | | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
OCME | | | | 29d. Date signed (Month, Day, Year)
AUGUST 16, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year)
AUG 18 2000 | | | | 32. Registrar's Signature
 | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27447

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francisco A. Gaitan

2. Date of Death

Month Day Year
Aug 9 2000

3. Time of Death

10:50 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

219-06-1788

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov 3, 1920

9. Birthplace (State or Foreign Country)

Nicaragua

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7119 Mill Run Drive

10f. Zip Code

20855

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify: Nicaraguan

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Pedro Gaitan

18. Mother's Name (First, Middle, Maiden Surname)

Ana Julia Castro

19a. Informant's Name/Relationship (Type, Print)

Yelba C. Gaitan/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7119 Mill Run Drive, Rockville, MD 20855

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

8/14/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. gastric cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

upper gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D43083

29d. Date signed (Month, Day, Year)

August 09, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE A. SOTOS MD 9707 Medical Center Drive #300 Rockville, MD 20850

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27448

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DAVIS W. GILBERT | | | | 2. Date of Death
Month Day Year
AUG. 13, 2000 | | 3. Time of Death
16:40 PM | |
| | 4a. Facility Name (If not institution, give street and number)
DEAL ISLAND ROAD | | | | 4b. City, Town, or Location of Death
CHANCE | | 4c. County of Death
SOMERSET | |
| Funeral
Director | 5. Social Security Number
223-26-6230 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 4, 1923 | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
SOMERSET | | 10c. City, Town or Location
CHANCE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
DEAL ISLAND ROAD | | 10f. Zip Code
21821 | | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
WELDER | | 16b. Kind of Business/Industry
WELDING/CONSTRUCTION | | | |
| | 17. Father's Name (First, Middle, Last)
AUBREY A. GILBERT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MYRTLE HANDY | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JAMES F. GILBERT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2273 SPRING ROAD, PATRICK SPRINGS, VA. 24133 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SALISBURY CREMATORY | | 20c. Location - City or Town, State
8/15/00 SALISBURY, MD. | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> MOO295 | | | | 22. Name and Address of Facility
HINMAN FUNERAL HOME, PRINCESS ANNE, MD. 21853 | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
MYOCARDIAL INFARCTION
Due to (or as a consequence of):
ASCVD
Due to (or as a consequence of):
SEVERAL YRS | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> Dorothy C. Holzworth, M.D. | | 29c. License number
806241 | | 29d. Date signed (Month, Day, Year)
08-15-00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD 21863 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
<i>[Signature]</i> B. Sparks | | | | | |
| | 33. Date of death (Month, Day, Year)
AUG 13 2000 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

00 27449

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
HENRY GRATHAM | | | | 2. DATE OF DEATH
MONTH 07 DAY 29 YEAR 2000 | | 3. TIME OF DEATH
0545 M | |
| 4. SOCIAL SECURITY NUMBER
213-62-0443 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
3-24-31 | |
| 9a. FACILITY NAME (If not institution, give street and number)
EASTERN CORRECTIONAL INSTITUTION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
WESTOVER | | 9c. COUNTY OF DEATH
SOMERSET | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
PRINCE GEORGES | | 10c. CITY, TOWN OR LOCATION
UPPER MARLBORO | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
4423 DERY RD | | | | 10f. ZIP CODE
20772 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4 or 5+) LABORER | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
LABORER | | 16b. KIND OF BUSINESS/INDUSTRY
FARM INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last)
HENRY GRATHAM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
FLORA KENYON | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MICHAEL GRATHAM - SON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4423 DERY RD UPPER MARLBORO, MD 20772 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
BRANCH CEMETERY | | 20c. LOCATION — City or Town, State
8-7-00 PINK HILL, N.C. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Anthony E. Waulgo | | | | 22. NAME AND ADDRESS OF FACILITY
Anthony E. Ward Funeral Home
30639 Hampden Ave., MD 21853 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. DILATED CARDIOMYOPATHY | | | | Approximate Interval Between Onset and Death
ONE YEAR | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. CONGESTIVE HEART FAILURE | | | | 6 MONTHS | |
| | | c. ATRIAL FIBRILLATION | | | | ONE YEAR | |
| | | d. HYPERTENSION | | | | 7-10 YEARS | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NONE | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PRISON INFIRMARY | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] MD | | | | 29c. LICENSE NUMBER
D0050826 | | 29d. DATE SIGNED (Month, Day, Year)
7/29/00 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LAZAAK A. ENIOLA, ECI 30420 REVELL'S NECK RD WESTOVER, MD 21890 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
AUG 07 2000 | | | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27450

| | | | | | | | | | | |
|---|--|--|---|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jacqueline Jean Herlihy | | | | 2. Date of Death
Month Day Year
August 8, 2000 | | | | 3. Time of Death
19:20 | |
| | 4a. Facility Name (If not institution, give street and number)
19930 Wild Cherry Lane | | | | 4b. City, Town, or Location of Death
Germantown | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
135-36-6541 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
53 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 19, 1946 | | 9. Birthplace (State or Foreign Country)
New Jersey | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
Md. | | 10b. County
Montgomery | | 10c. City, Town or Location
Germantown | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
19930 Wild Cherry Lane | | | | 10f. Zip Code
20874 | | | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Elementary Teacher | | | | 16b. Kind of Business/Industry
Education | |
| | 17. Father's Name (First, Middle, Last)
John Francis Herlihy | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Thelma Koellhoffer | | | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Jeffrey A. Sizemore (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10518 Tralee Terr. Damascus, Md. 20872 | | | | | |
| | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Sepulchre Cemetery | | Date
Aug. 17, 2000 | | 20c. Location - City or Town, State
East Orange, N.J. | |
| | 21. Signature of Funeral Service Licensee
Curtis E. Day | | | | 22. Name and Address of Facility
DeVol Funeral Home
10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Carbon monoxide intoxication
Due to (or as a consequence of):
b. Depression
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Approximate Interval Between Onset and Death
years | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year)
August 8, 2000 | | 28b. Time of Injury
7:20 PM | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
self-inflicted asphyxiation | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Garage attached to home | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
19930 Wild Cherry Lane, Germantown, MD | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Patricia L. Tomsko, MD | | | | 29c. License number
D51916 | | | | 29d. Date signed (Month, Day, Year)
August 8, 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27451

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|--|--|--|--|--|---|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Bernard Helene | | | | 2. Date of Death
Month August Day 14 Year 2000 | | | | 3. Time of Death
8:15 am | | | | |
| | 4a. Facility Name (If not Institution, give street and number)
5620 Massachusettes Avenue | | | | 4b. City, Town, or Location of Death
Bethesda | | | | 4c. County of Death
Montgomery | | | | |
| Funeral
Director | 5. Social Security Number
123-03-8452 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
92 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jul 2, 1908 | | 9. Birthplace (State or Foreign Country)
NY | | | | |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
5620 Massachusettes Avenue | | | | 10f. Zip Code
20816 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Stenographer | | | | 16b. Kind of Business/Industry
Legal | | | | | |
| 17. Father's Name (First, Middle, Last)
Charles Helene | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown Salinsky | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Charles E. Helene / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5620 Massachusettes Avenue, Bethesda, MD 20816 | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | | 20c. Location - City or Town, State
8/15/00 Alexandria, VA | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring MD 20901 | | | | | | | | | |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
Chronic | | | | | |
| b. _____
Due to (or as a consequence of): | | | | c. _____
Due to (or as a consequence of): | | | | d. _____ | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Abdominal Aortic Aneurysm

Chronic Severe Systemic Hypertension | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
M | | | | 28b. Time of Injury
1 Yes <input type="checkbox"/> No | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D0028064 | | | | | |
| 29d. Date signed (Month, Day, Year)
8/14/00 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward N. Bodurian MD, 5530 Wisconsin Avenue Suite 515, Chevy Chase MD 20815 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend #10e, 19b, 8/25/2000, BMW, Montg. Co.

Reg. No. 00 27452

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roberta M.P. Hayes

2. Date of Death

Month Day Year
August 10, 2000

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-36-2043

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 29, 1923

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5808
5805 Melvern Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)Director of
Christian Education

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Alonzo Robertson Pixley

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Priscilla MacIntyre

19a. Informant's Name/Relationship (Type, Print)

Joseph M. Hayes/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5808
5805 Melvern Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

Aug. 14,
2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Stroke

Approximate
Interval Between
Onset and Death

2 days

Due to (or as a consequence of):

b. Atherosclerosis

6 years

Due to (or as a consequence of):

c. Hypercholesterolemia

6 years

Due to (or as a consequence of):

d. Diabetes Mellitus, Type II

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D30844

29d. Date signed (Month, Day, Year)

Aug 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James F. McMurry, Jr., M.D. 4701 Randolph Road, Suite 103, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27453

| | | | | | | | | | |
|---|---|---------------------------------------|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Theresa F. Hathaway | | | | 2. Date of Death
Month Day Year
August 12, 2000 | | 3. Time of Death
2:00A. | | |
| | 4a. Facility Name (If not institution, give street and number)
9703 52nd Avenue | | | | 4b. City, Town, or Location of Death
College Park | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
028-22-0022 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 13, 1929 | | |
| | 9. Birthplace (State or Foreign Country)
Massachusetts | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
College Park | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
9703 52nd Avenue | | | | 10f. Zip Code
20740 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
own home | | | |
| 17. Father's Name (First, Middle, Last)
Antone Mayo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Silvia | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
John P. Hathaway (husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
same as #10 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Cemetery | | Date
8/15/2000 | | 20c. Location - City or Town, State
Rockville, Maryland | | |
| 21. Signature of Funeral Service Licensee
Donald V. Borgwardt | | | | 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | |
| Approximate Interval Between Onset and Death
3 years | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Michael Beard | | | 29c. License number
D26287 | | 29d. Date signed (Month, Day, Year)
8/13/2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M BERARD, M.D. 7305 BALTIMORE AVE 107 COLLEGE PARK, MD 20740 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

00 27454

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
NICHOLAS W. HANDY | | | | 2. DATE OF DEATH
MONTH 08 DAY 13 YEAR 2000 | | 3. TIME OF DEATH
0835 M | |
| 4. SOCIAL SECURITY NUMBER
222-34-3502 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
47 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
09-09-52 | |
| 9a. FACILITY NAME (If not institution, give street and number)
EASTERN Correctional Institution | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
WESTOVER | | 9c. COUNTY OF DEATH
SOMERSET | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
SOMERSET | | 10c. CITY, TOWN OR LOCATION
MANOKIN | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
P.O. Box 21 | | | | 10f. ZIP CODE
21836 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
SELF - EMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY
Mechanic | | | |
| 17. FATHER'S NAME (First, Middle, Last)
JAMES HANDY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MAGdalene Collins | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sharon Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Louise RD New Castle, DE 19720 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Handy Family Cemetery 8-9-04 Upper Hill, MD | | 20c. LOCATION — City or Town, State
MD | | 22. NAME AND ADDRESS OF FACILITY
Anthony E. Ward Funeral Home 21853
30639 Hampden Ave. Princess Anne, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Anthony E. Ward F.D. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. TERMINAL AIDS | | | | Approximate Interval Between Onset and Death
13 MONTHS | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. PARAPLEGIA | | | | 3 MONTHS | |
| | | c. DEMENTIA | | | | 3 MONTHS | |
| | | d. MULTIPLE DECUBITUS ULCERS | | | | 3 MONTHS | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NONE | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PRISON INFIRMARY | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
[Signature] | | | | 29c. LICENSE NUMBER
D0050826 | | 29d. DATE SIGNED (Month, Day, Year)
8/13/00 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PAZAAK-ENIOLA ECI 30420 REVELL'S NECK RD WESTOVER MD 21890 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
AUG 16 2000 | | 32. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28

101 102-103

111

The first of these is the fact that the first of the three is the most important

and the second is the most important

and the third is the most important

and

and the first of these is the most important

and

and the second of these is the most important

and the third of these is the most important

and the first of these is the most important

and the second of these is the most important

and the third of these is the most important

and the first of these is the most important

and the second of these is the most important

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27455

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA ERLENE HINMAN

2. Date of Death

Month
8Day
9Year
2000

3. Time of Death

2005

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

218-16-8614

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02/28/1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD.

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

30124 Peggy Lane

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

none

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Early Midgett

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Ewell

19a. Informant's Name/Relationship (Type, Print)

James L. Hinman, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30124 Peggy Lane, Princess Anne, Md. 21853

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beechwood Cemetery

Date

8/12/00

20c. Location - City or Town, State

Princess Anne, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hinman Funeral Home

M00295

11673 Somerset Ave., Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC CARDIOMYOPATHY, OLD

MYOCARDIAL INFARCTION, HYPERTENSION, SPINAL CEREBELLAR

DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0003599

29d. Date signed (Month, Day, Year)

8-10-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D.

106 MILFORD ST

SALISBURY, MARYLAND

21804

31. Date filed (Month, Day, Year)

AUG 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

X

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

31. 32. 33. 34. 35. 36. 37. 38. 39. 40.

41. 42. 43. 44. 45. 46. 47. 48. 49. 50.
51. 52. 53. 54. 55. 56. 57. 58. 59. 60.
61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
71. 72. 73. 74. 75. 76. 77. 78. 79. 80.

ADMEND ITEMS: #28A-F PER MEO G793 3-8-01 WR

AMEND ITEM: #23A PART I 28A-F PER MEO G792 2-16-01 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27456

| | | | | | |
|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edward Harrison Haines | | 2. Date of Death
Month August Day 5 Year 2000 | | 3. Time of Death
1657 |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO |
| Funeral
Director | 5. Social Security Number
219-18-2233 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 | 8. Date of Birth (Month, Day, Year)
07-27-1924 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
Somerset | 10c. City, Town or Location
Westover | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
26809 Rumbley Road | | 10f. Zip Code
21871 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1943-51 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) none | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Examiner | | 16b. Kind of Business/Industry
Dept. of Motor Vehicles | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
William R. Cavey | | 18. Mother's Name (First, Middle, Maiden Surname)
Marie Cavey | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Alan Armstrong/P.O.A. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cornstalk Road, Marion, Md. 21838 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beechwood Cemetery | | 20c. Location - City or Town, State
8/10/00 Princess Anne, Md. |
| | 21. Signature of Funeral Service Licensee
<i>James L. Haines</i> M00295 | | 22. Name and Address of Facility
Hinman Funeral Home
11673 Somerset Ave., Princess Anne, Md. 21853 | | |
| | Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.
HEAD AND NECK INJURIES WITH COMPLICATIONS | | | | |
| Immediate Cause (Final disease or condition resulting in death)
<i>Arteriosclerotic Cardiovascular Disease</i>
Due to (or as a consequence of):
b. <i>Chronic Obstructive Pulmonary Disease</i>
Due to (or as a consequence of):
c. <i>Hyperension, Diabetes Mellitus</i>
Due to (or as a consequence of):
d. <i>Asbestosis, Head Injury, Spinal Injury</i> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic Obstructive Pulmonary Disease</i>
<i>Hyperension, Diabetes Mellitus</i>
<i>Asbestosis, Head Injury, Spinal Injury</i> | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year)
6-6-2000 | | | | | |
| 28b. Time of Injury
11:15 M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred
SUBJECT FELL STRIKING HIS HEAD ON A GLASS DISPLAY CASE. | | | | | |
| 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)
HOTEL LOBBY | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
AMALOB, FRANCE | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>Gregorio M. Belloso M.D.</i> | | | | | |
| 29c. License number
D 29505 | | | | | |
| 29d. Date signed (Month, Day, Year)
8-7-2000 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 08 2000 | | | | | |
| 32. Registrar's Signature
<i>Geneva B. Sparks</i> | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 27457

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William John Jones

2. Date of Death

Month 8 Day 12 Year 2000

3. Time of Death

1:15 AM

4a. Facility Name (If not Institution, give street and number)

Springbrook Adventist Nursing & Rehab.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

172-10-2242

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
May 7, 1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12310 Brookhaven Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Washington Newsweek

17. Father's Name (First, Middle, Last)

William Walker Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Shaeffer

19a. Informant's Name/Relationship (Type, Print)

Grover H. Jones / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Main Street P.O. Box 192, Wachapreague, VA 23480

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parlawn Memorial Park 8/15/00 Rockville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eric S. Scordo

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis

Due to (or as a consequence of):

b. Urinary Tract Infection

Due to (or as a consequence of):

c. End Stage Renal Disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Upper Gastrointestinal bleeding, Anemia

Diabetes Mellitus, Diabetic neuropathy, Diabetic

Retinopathy, Multiple Decubitus Ulcers

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yusef

29c. License number

D51083

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yisa O. Yussuf, MD 6712 Village Park Drive, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27458

| | | | | | | | | | | |
|--|---|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Barbara Alice Johnson | | | | 2. Date of Death
Month Day Year
August 12, 2000 | | | | 3. Time of Death
10:05 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
067-42-2591 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
50 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 23, 1950 | | 9. Birthplace (State or Foreign Country)
New York | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4977 Battery Lane, # 613 | | | | 10f. Zip Code
20814 | | | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Attorney | | | | 16b. Kind of Business/Industry
United States Department of Justice | | |
| 17. Father's Name (First, Middle, Last)
Peter Magdziak | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Irene Dmoch | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Helen E. Thomas/ Aunt | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 Barclay Lane, Cherry Hill, NJ 08034 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | Date
August 14, 2000 | | 20c. Location - City or Town, State
Bethesda, Maryland | | | | |
| 21. Signature of Funeral Service Licensee
 MO0689 | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,
Bethesda, Maryland 20814-3501 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>Metastatic Adenocarcinoma of Cervix</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
3 years | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D22775 | | 29d. Date signed (Month, Day, Year)
August 13, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Frederick G. Barr, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27459

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mae M. Johns | | | | 2. Date of Death
Month Day Year
August 12, 2000 | | 3. Time of Death
2:40 AM. | |
| | 4a. Facility Name (If not institution, give street and number)
Suburban Hospital | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
244-10-6549 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 26, 1919 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
D.C. | | 10b. County
Washington, D.C. | | 10c. City, Town or Location
Washington, D.C. | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
4201 Butterworth Pl. # 422 | | 10f. Zip Code
20016 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary Trust Department | | 16b. Kind of Business/Industry
Riggs Bank | | 17. Father's Name (First, Middle, Last)
John David Johns | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Barbour | | 19a. Informant's Name/Relationship (Type, Print)
Estelle David - Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 W. Market St., Port Penn, De. 19731 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Crematory | | 20c. Date
8/17/00 | | 20d. Location - City or Town, State
Falls Church, Va. | | 21. Signature of Funeral Service Licensee
Thomas E. Honnaker | |
| | 22. Name and Address of Facility
Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. NW., Washington, D.C. 20016 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

b. Pneumonia
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death

3 Days

3 Days | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Metastatic Brain Tumor

Osteoporosis | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
8/12/00 | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D19609 | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
8.12.00 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raman R. Tuli, MD. 11810 Darnestown Rd. # 202, Gaithersburg, Md. 20878 | | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
[Signature] | |
| | 33. State Registrar
State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. Johns, Mae M. 8/12/00 2:40 AM | | 36. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27460

| | | | | | | | | | |
|---|---|---|--|---|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elgin Preston Jenkins Jr. | | | | 2. Date of Death
Month 8 Day 15 Year 2000 | | 3. Time of Death
4:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
Holy Cross Hospital | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
434-44-4941 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sep 8, 1931 | | |
| | 9. Birthplace (State or Foreign Country)
LA | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
9533 Clement Road | | 10f. Zip Code
20901 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dentist | | 16b. Kind of Business/Industry
Self Employed | | | | | |
| 17. Father's Name (First, Middle, Last)
Elgin Preston Jenkins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Louise Jeffrion | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Valda Jenkins/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9533 Clement Road, Silver Spring, MD 20901 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | Date
8/21/00 | | 20c. Location - City or Town, State
Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee
Steven T. Kariya | | 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd.W.
Silver Spring MD 20901 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. PNEUMOTHORAX
Due to (or as a consequence of):
c. PULMONARY FIBROSIS
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
1 DAY
1 DAY
24RS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS, MYELODYSPLASIA | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Steven T. Kariya - MD | | 29c. License number
D36252 | | 29d. Date signed (Month, Day, Year)
August 15, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
STEVEN T. KARIYA, MD, 11501 GEORGIA AVE STE. 515 WASHINGTON MD 20902 | | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
B. Sparks | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27461

| | | | | | | | | |
|---|---|--|---|--------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CORA JANIE JACKSON | | | | 2. Date of Death
Month Day Year
August 14 2000 | | 3. Time of Death
0702 | |
| | 4a. Facility Name (If not institution, give street and number)
3009 Oxon Run Court | | | | 4b. City, Town, or Location of Death
Temple Hills | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
226-323957 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
4-10-1921 | 9. Birthplace (State or Foreign Country)
Va. | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | 10b. County
Prince Georges | 10c. City, Town or Location
Temple Hills | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
3009 Oxon Run Ct. | | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
U.S.A | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (14 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Home | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
William Edward Redd | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Wood | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Pauline Marie Lee - Howard | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Tracy St. Stafford, Va. 22554 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Valley Mem. Park | | Date
8/21/00 | | 20c. Location - City or Town, State
Annandale, Va. | |
| | 21. Signature of Funeral Service Licensee
Bernardo Amer | | | | 22. Name and Address of Facility
Ames Funeral Home, Inc.
8914 Quarry Rd. Manassas, Va. 20110 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier
(Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
Salvador Silvestre MD | | | | 29c. License number
H0055927 | | 29d. Date signed (Month, Day, Year)
August 16, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Salvador Silvestre 3001 Hospital Drive, Cheverly, Maryland 20785 | | | | | | | |
| To Be Completed by Registrar | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | | | 32. Registrar's Signature
B. Sparks | | | |
| | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

amend item 20b,c per fh G787 9/18/00 yf

Certificate of Death

Reg. No.

00 27462

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Christa D. Konrad | | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | 3. Time of Death
6:15 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
Springhouse | | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | | |
| Funeral
Director | 5. Social Security Number
282-34-2826 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 30, 1934 | | 9. Birthplace (State or Foreign Country)
Germany | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Montgomery | | | 10c. City, Town or Location
Bethesda | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
4925 Battery Lane #201 | | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
United States | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Vice President | | | 16b. Kind of Business/Industry
Center for Strategic & International Studies | | | |
| 17. Father's Name (First, Middle, Last)
Josef Konrad | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Dinges | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Iola Morrissey/Executrix | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2905 Sycamore Street Alexandria, Virginia 22305 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chestnut Woods | | Date of Disposition
8/26/2000 | | 20c. Location - City or Town, State
Franklin, West Virginia | | | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> M00335 | | | | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557
Bethesda, Maryland 20814-3501 | | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death
7 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cellulitis | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
<i>Carolyn L. Baier MD</i> | | | | | 29c. License number
D34386 | | 29d. Date signed (Month, Day, Year)
August 11, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carolyn L. Baier, M.D., 1396 Piccard Drive, Rockville, Maryland 20850 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27463

Amend #19a, 8/18/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isidoros C. Kondilis

2. Date of Death

Month Day Year
August 13, 2000

3. Time of Death

6:00pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8907 Connecticut Avenue

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

578-92-7401

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 1, 1937

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8907 Connecticut Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

self employed carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Constantinos Kondilis

18. Mother's Name (First, Middle, Maiden Surname)

Denise Knitou

19a. Informant's Name/Relationship (Type, Print)

Kyriaki
Denise Kondilis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8907 Connecticut Avenue, Chevy Chase, Md 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven

Date

8/16/00

20c. Location - City or Town, State

Silver Spring, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE
11818 New Hampshire Ave. Silver Spring, Md23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. EXT adenocarcinoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D19714

29d. Date signed (Month, Day, Year)

8/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL PETER JYBML 4940 BAYVIEW AVE, BALTIMORE, MD 21224

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-343-0000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27464

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther

Kominers

2. Date of Death

Month Day Year
August 13, 2000

3. Time of Death

6:30P.

4a. Facility Name (If not institution, give street and number)

9010 Burdette Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

579-24-2431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 1, 1913

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9010 Burdette Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Meyer

Koplow

18. Mother's Name (First, Middle, Maiden Sumame)

Fannie

Schiller

19a. Informant's Name/Relationship (Type, Print)

Abbot Kominers (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8214 Ellingson Drive Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial Garden 8/15/2000 Falls Church, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

10 days

Due to (or as a consequence of):

b. Cerebrovascular Accident

4 years

Due to (or as a consequence of):

c. Hypertension

40 years

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D24886

29d. Date signed (Month, Day, Year)

August 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark H. Eig, M.D. 10801 Lockwood Drive Silver Spring, Maryland 20901

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27465

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary A. Kerley

2. Date of Death

August 12 2000

3. Time of Death

0420 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

711-12-1697

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 1, 1921

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

715 Maiden Choice Lane (PV 418)

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Aloysius J. Bier

18. Mother's Name (First, Middle, Maiden Surname)

Margaret E. Batton

19a. Informant's Name/Relationship (Type, Print)

Bernadette Maertens/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1472 Sharps Point Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

8/17/00

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Eric S. Sculco

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W.
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. critical Aortic stenosis

Due to (or as a consequence of):

c. CAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. M. B. B. B.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

August 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMEL DORCEK, DO SINAI HOSPITAL

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

James B. Sparks

State
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27466

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Claude Spencer Leffel, Jr. | | | | 2. Date of Death
Month Day Year
August 13 2000 | | 3. Time of Death
12:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Fairhaven Life Care Center | | | | 4b. City, Town, or Location of Death
Sykesville | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
215-20-9915 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec 21, 1921 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
7200 Third Avenue | | | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+)
8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Physicist | | 16b. Kind of Business/Industry
Applied Physics | |
| | 17. Father's Name (First, Middle, Last)
Claude Spencer Leffel | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Kate Lee Childress | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (Wife)
Mrs. Virginia Dorsey Leffel | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7200 Third Avenue Sykesville, MD 21784 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation Srv. | | 20c. Location - City or Town, State
8/14/2000 Sykesville, MD | | | |
| | 21. Signature of Funeral Service Licensee
Brian A. Haight | | | | 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Prostate Cancer | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and Title of certifier
MD | | | | 29c. License number
D34849 | | 29d. Date signed (Month, Day, Year)
August 14 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Tan, MD 1645 Liberty Road Eldersburg MD 21784 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature
Benjamin B Sparks | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MATHEW EDWARD LEWIS

AMEND ITEMS: #23 PART I, 27, 28A-E

Certificate of Death

Reg. No.

00 27467

| | | | | | | | | | | |
|--|--|---|--|---|--|--|----------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Matthew Edward Lewis | | | | 2. Date of Death
Month Day Year
AUG. 13, 2000 | | | | 3. Time of Death
11:35 AM | |
| | 4a. Facility Name (If not institution, give street and number)
4919 JAMESTOWN ROAD | | | | 4b. City, Town, or Location of Death
BETHESDA | | | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
226-66-9463 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
Dec. 27, 1957 | | 9. Birthplace (State or Foreign Country)
Australia | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| Usual Residence of Decedent | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
4919 Jamestown Road | | 10f. Zip Code
20816 | | 10g. Citizen of What Country?
United States | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4 or 5+) 2 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Copier Repairman | | 16b. Kind of Business/Industry
Xerox | | 17. Father's Name (First, Middle, Last)
Theodore L. Lewis | | 18. Mother's Name (First, Middle, Maiden Surname)
Constance Mary Houghton | | 19a. Informant's Name/Relationship (Type, Print)
Constance M. Houghton/ Mother | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4919 Jamestown Road, Bethesda, Maryland 20816 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | 20c. Date
August 15, 2000 | | 20d. Location - City or Town, State
Bethesda, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 | | 23a. Part I. Under this disease, or complications that caused the death, shock or heart failure. List only one cause on each line.
ANTI-DEPRESSANT (AMITRIPTYLINE) INTOXICATION | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 23c. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 23d. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found: 8-13-00 | | 28b. Time of Injury
UNKNOWN | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Subject took overdose of anti-depressant drug | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND: HOME | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4919 JAMESTOWN ROAD BETHESDA, MONT. CO. MD | | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | | |
| 29d. Date signed (Month, Day, Year)
AUG. 14, 2000 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
 | | 33. Registrar
State Registrar | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 27468

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES LEGION | | 2. Date of Death
Month Day Year
AUGUST 13, 2000 | | 3. Time of Death
10:38AM |
| | 4a. Facility Name (If not institution, give street and number)
HOLY CROSS HOSPITAL | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY |
| Funeral
Director | 5. Social Security Number
416-38-8298 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
MARCH 21, 1932 | | 9. Birthplace (State or Foreign Country)
ALABAMA | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
DC | | 10b. County
N/A | | 10c. City, Town or Location
WASHINGTON | |
| 10e. Street and Number
125 ATLANTIC STREET S.E. | | 10f. Zip Code
20032 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12TH
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Psychiatric Nursing Assistant | | 16b. Kind of Business/Industry
GOVERNMENT | |
| 17. Father's Name (First, Middle, Last)
JAMES LEGION | | | 18. Mother's Name (First, Middle, Maiden Surname)
LILLIE JOHNSON | | |
| 19a. Informant's Name/Relationship (Type, Print)
LINCOLN LEGION (WIFE) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1710 T. STREET S.E. APT. 102, WASH, DC. 20020 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LINCOLN CEMETERY | | 20c. Location - City or Town, State
SUITLAND, MARYLAND | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH STREET N.W. WASHINGTON, DC. 20011 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | ANOXIC ENCEPHALOPATHY | | | Approximate Interval Between Onset and Death
2 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. Due to (or as a consequence of):
POSTOPERATIVE RESPIRATORY ARREST | | | 2 WEEKS |
| | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D35336 | | 29d. Date signed (Month, Day, Year)
AUGUST 13, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DEENA J. SHAPIRO, M.D. 10810 CONNECTICUT AVE., KENSINGTON, MD. 20895 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-858-8000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27469

| | | | | | | | | |
|---|---|---|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ernest H. McLAREN | | | | 2. Date of Death
Month AUG Day 10 Year 2000 | | 3. Time of Death
13:45 | |
| | 4a. Facility Name (If not institution, give street and number)
SINAI HOSPITAL 2401 W. BELVEDERE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death | |
| Funeral
Director | 5. Social Security Number
218-01-6395 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 29 1912 Md | | 9. Birthplace (State or Foreign Country) |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Marriottsville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3839 Wards Chapel Road | | | | 10f. Zip Code
21104 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) 6 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
custodian | | | 16b. Kind of Business/Industry
Balto. Co. Board of Education | |
| 17. Father's Name (First, Middle, Last)
Robert McLaren | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Six | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
E. Irene New (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6600 Gigi Dr., Woodbine, Md 21797 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park 8-14-2000 | | 20c. Location - City or Town, State
Sykesville, Md. | | |
| 21. Signature of Funeral Service Licensee
Paula Haight Herbert | | | | 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. COPD = CHRONIC OBSTRUCTIVE PULM. DISEASE
Due to (or as a consequence of):
c. PNEUMONIA
Due to (or as a consequence of):
d. MYOCARDIAL INFARCTION | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Justin E. Erickson MD | | | | 29c. License number
P14260 | | 29d. Date signed (Month, Day, Year)
AUG 10 2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KRISTIN E. ERICKSON SINAI HOSPITAL 2401 BELVEDERE AVE BALT, MD 21215 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
Benjamin B. Sparks | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

McLAREN, ERNEST H

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27470

Amend #18, 8/18/2000, JW, Montg. Co.

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Laura H. Mull | | | | 2. Date of Death
Month Day Year
AUGUST 11 2000 | | | | 3. Time of Death
02:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
300-03-2829 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec. 7, 1908 | | 9. Birthplace (State or Foreign Country)
West Virginia | |
| | 10a. State
Maryland | | | | 10b. County
Howard | | 10c. City, Town or Location
Laurel | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
8240 Sandy Stream Road | | | | 10f. Zip Code
20723 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretarial | | | | 16b. Kind of Business/Industry
Private Industry | | | |
| | 17. Father's Name (First, Middle, Last)
John Herbert | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rhoda Benton H. Trent | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Benton H. Mull (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8240 Sandy Stream Road Laurel, Maryland 20723 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
8/14/00 Brentwood, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee
Stevie D Stroud | | | | 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
osteoporosis | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | Approximate Interval Between Onset and Death
4 days | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
dementia, dysphagia, contractures,
osteoporosis | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D41104 | | 29d. Date signed (Month, Day, Year)
8 11, 00 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ted Hawk MD 7825 York Rd Towson, MD 21204 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
[Signature] | | | | | | | |

ORIGINAL

James T. Morgan, Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO G786 WR

AMEND ITEMS: #23 PART I, 27, 28A-F PER Certificate of Death

Reg. No.

00 27471

| | | | | | |
|---|---|--------------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James Thomas Morgan, Jr. | | 2. Date of Death
Month Day Year
August 10, 2000 | | 3. Time of Death
1344 pm |
| | 4a. Facility Name (If not institution, give street and number)
3131 Branch Avenue, Room #102 | | 4b. City, Town, or Location of Death
Temple Hills | | 4c. County of Death
Prince George's |
| Funeral
Director | 5. Social Security Number
219-68-4197 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
40 Yrs. | 8. Date of Birth (Month, Day, Year)
August 1, 1960 | 9. Birthplace (State or Foreign Country)
Washington, DC |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Prince Georges | 10c. City, Town or Location
Laurel | | 10d. Inside City Limits
1 Yes 2 No |
| | 10e. Street and Number
7801 Brooklyn Bridge Road | | 10f. Zip Code
20707 | | 10g. Citizen of What Country?
United States |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Not Available | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Self-Employed | | 16b. Kind of Business/Industry
Carpentry | | |
| | 17. Father's Name (First, Middle, Last)
James Thomas Morgan, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Bowman | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Pamela J. Morgan-Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3304 Haviland Court, #202, Palm Harbor, FL 34684 | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State
Bethesda, Maryland |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
M00689 | | 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | |
| | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | | | | |
| | 24a. Was an autopsy performed?
1 Yes 2 No | | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | | | | |
| | 25. Was case referred to medical examiner?
XX Yes 2 No | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene | | | | |
| | 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)
Found: 8-10-00 | | | | |
| | 28b. Time of Injury
FOUND: 1:30 P | | | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
1 Yes 2 No | | | | |
| | 28d. Describe how injury occurred
UNKNOWN | | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
3131 BRANCH AVE. TEMPLE HILLS, MARYLAND | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
FOUND: MOTEL | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
O.C.M.E. | | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
O.C.M.E. | | | | |
| | 29d. Date signed (Month, Day, Year)
August 11, 2000 | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| | 31. Date filed (Month, Day, Year)
AUG 14 2000 | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
B. Sparks | | | | |
| | 33. Date filed (Month, Day, Year)
AUG 14 2000 | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27472

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Amerigo Manzi

2. Date of Death

Month

Day

Year

3. Time of Death

6:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

065-07-5823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 6, 1912

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10033 Renfrew Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Assistant Director

16b. Kind of Business/Industry

IRS

17. Father's Name (First, Middle, Last)

Caesare Manzi

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Ciavatti

19a. Informant's Name/Relationship (Type, Print)

Beverly L. Manzi/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10033 Renfrew Road, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

8/18/00 Silver Spring

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility Francis J. Collins Funeral Home

500 University Blvd. W.
Silver Spring MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

48 Hours

b. Myelodysplastic Syndrome

Due to (or as a consequence of):

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer, Radiation Therapy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Daniel Rosenblum

29c. License number

D04766

29d. Date signed (Month, Day, Year)

8/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Rosenblum, MD 10400 Connecticut Ave Suite 606 Kensington, MD 20895

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27473

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Salim Mangerua | | | | 2. Date of Death
Month Day Year
August 13, 2000 | | | | 3. Time of Death
12:14a | | |
| | 4a. Facility Name (If not Institution, give street and number)
Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death
Takoma Park | | | | 4c. County of Death
M.C. | | |
| Funeral
Director | 5. Social Security Number
578-86-8041A | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
12-12-1932 | | 9. Birthplace (State or Foreign)
Somalia | | |
| | Usual Residence of Decedent | | | | 10a. State
Md. | | | | 10b. County
M.C. | | |
| 10c. City, Town or Location
Takoma Park | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number
7777 Maple Ave. #1102 | | | | 10f. Zip Code
20912 | | | | 10g. Citizen of What Country?
Somalia | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef Assistant | | | | 16b. Kind of Business/Industry
Food | | | |
| 17. Father's Name (First, Middle, Last)
Mangerua Said | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mesosi Mengua | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sceknur Salim - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7667 Maple Ave. # 501 Takoma Pk. Md. | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Wash. Cem. | | | | Date
8-15-00 | | 20c. Location - City or Town, State
Adelphi, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Universal Mortuary
411 Kennedy St., N.W. | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Liver failure
Due to (or as a consequence of):
Cirrhosis
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Hepatitis C | | | | Approximate Interval Between Onset and Death
2 wks | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hepatitis C | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
 | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
 | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
D45660 | | 29d. Date signed (Month, Day, Year)
8-13-00 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Drinder Singh, M.D.
14300 CALLANT fex LN 124, Bowie MD 20716 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27474

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Rinaldo Macon

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

9:45 P.M.

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

216-72-0197

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 5, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13529 Glen Mill Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Robert C. Macon

18. Mother's Name (First, Middle, Maiden Surname)

Ines DiGiuseppe

19a. Informant's Name/Relationship (Type, Print)

Ines Macon/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13529 Glen Mill Road, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Aug. 17,
2000

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home / Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pulmonary hemorrhage
Due to (or as a consequence of):

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Aplastic Anemia
Due to (or as a consequence of):

years

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diastolic cardiac dysfunctionDown's syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying PhysicianTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D47791

29d. Date signed (Month, Day, Year)

August 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A Holden 809 Veirs Mill Rd, Rockville, MD 20851

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27475

| | | | | | | | | |
|---|---|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Royce Wade Mears | | | 2. Date of Death
Month Day Year
August 6 2000 | | 3. Time of Death
0800 | | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | | |
| Funeral
Director | 5. Social Security Number
225-32-9966 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
05/09/1927 | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
Somerset | | 10c. City, Town or Location
Princess Anne | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
11614 Somerset Avenue | | 10f. Zip Code
21853 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1954-56 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) none | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | 16b. Kind of Business/Industry
Automobile | | | | |
| 17. Father's Name (First, Middle, Last)
Jefferson D. Mears | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Holland | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Anita G. Mears/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11614 Somerset Ave., Princess Anne, Md. 21853 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beechwood Cemetery | | 20c. Date
8/9/00 | | 20d. Location - City or Town, State
Princess Anne, Md. | | |
| 21. Signature of Funeral Service Licensee
<i>James L. Dennis</i> M00295 | | | | 22. Name and Address of Facility
Hinman Funeral Home
11673 Somerset Ave., Princess Anne, MD. 21853 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>ischemic cardiomyopathy</u>
Due to (or as a consequence of):
b. <u>CAD</u>
Due to (or as a consequence of):
c. <u>CHF</u>
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Anthony J. Fry MD</i> | | | | 29c. License number
D53394 | | 29d. Date signed (Month, Day, Year)
8/6/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anthony J. Fry, MD 1315 S. Division Street, Salisbury, Md 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 08 2000 | | | | 32. Registrar's Signature
<i>Denise B. Sparks</i> | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27476

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VAN-LIEN NGUYEN | | | | 2. Date of Death
Month Day Year
Aug. 12, 2000 | | 3. Time of Death
6:50 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
214-47-2179 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 20, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Vietnam | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Potomac | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2418 Stratton Dr. | | 10f. Zip Code
20854 | | 10g. Citizen of What Country?
France | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Vietnamese | |
| To Be Completed by
Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Business Man | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
Van-Lien Nguyen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
So Thi | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Kim L. Doan /daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2418 Stratton Dr., Potomac, MD 20854 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
No. Virginia Crematory | | 20c. Location - City or Town, State
8/18/00 Arlington, VA 22203 | | 20d. Date | |
| To Be Completed by
Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Arlington Funeral Home
3901 N. Fairfax Dr., Arlington, Virginia 22203 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic Encephalopathy
Due to (or as a consequence of):
b. R Brain Stem CVA
Due to (or as a consequence of):
c. Aspiration Pneumonia
Due to (or as a consequence of):
d. Bradytachy syndrome | | | | | | | Approximate Interval Between Onset and Death
24 hrs
6 days
3 days
1 year |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 29b. Signature and title of certifier
 | | | | 29c. License number
D47295 | | 29d. Date signed (Month, Day, Year)
August 13, 2000 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
T. Ann Tonnu 9057 Shady Grove Ct., Gaithersburg, Md 20877 | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27477

| | | | | | | | | |
|--|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ETHEL CORINNE OFFUTT | | | | 2. Date of Death
Month Day Year
AUGUST 10, 2000 | | 3. Time of Death
0130 | |
| | 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital | | | | 4b. City, Town, or Location of Death
Olney | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
217-32-1977 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
Apr. 12, 1907 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
3500 Forest Edge Drive | | 10f. Zip Code
20906 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
11th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | | | | |
| 17. Father's Name (First, Middle, Last)
George H. Thomas | | 18. Mother's Name (First, Middle, Maiden Surname)
Mamie Snowden | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mable Thomas (Sister) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 Norwood Rd., Silver Spring, MD 20905 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mutual Mem. Cem. | | Date
8/15/00 | | 20c. Location - City or Town, State
Sandy Spring, MD | | |
| 21. Signature of Funeral Service Licensee
<i>George R. Snowden</i> | | 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
PNEUMONIA
Due to (or as a consequence of):
MULTIPLE MYELOMA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
ANEMIA
CORONARY ARTERY DISEASE | | Approximate Interval Between Onset and Death
3 DAYS
3 YRS | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Donald R. Lewis MD</i> OTD | | 29c. License number
D06406 | | 29d. Date signed (Month, Day, Year)
August 10, 2000 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
DONALD R. LEWIS MD 4000 RT108 OLNEY, MD 20832 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 14 2000 | | 32. Registrar's Signature
<i>B. Sparks</i> | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report
describes the general situation
of the country in 1950.

2. The second part of the report

describes the general situation
of the country in 1951.
The third part of the report
describes the general situation
of the country in 1952.

The fourth part of the report
describes the general situation
of the country in 1953.
The fifth part of the report
describes the general situation
of the country in 1954.

The sixth part of the report
describes the general situation
of the country in 1955.
The seventh part of the report
describes the general situation
of the country in 1956.

The eighth part of the report
describes the general situation
of the country in 1957.
The ninth part of the report
describes the general situation
of the country in 1958.

The tenth part of the report
describes the general situation
of the country in 1959.
The eleventh part of the report
describes the general situation
of the country in 1960.

The twelfth part of the report
describes the general situation
of the country in 1961.
The thirteenth part of the report
describes the general situation
of the country in 1962.

The fourteenth part of the report
describes the general situation
of the country in 1963.
The fifteenth part of the report
describes the general situation
of the country in 1964.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27478

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BERTON REED OTTO | | | | 2. Date of Death
Month Day Year
August 15 2000 | | 3. Time of Death
7:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
National Navel Medical Center | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
543-01-7770 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 9, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Oregon | | 10a. State
Virginia | | 10b. County
Stafford | | 10c. City, Town or Location
Stafford | |
| To Be Completed by Funeral Director | 10e. Street and Number
1009 Potomac Dr. | | 10f. Zip Code
22554 | | 10g. Citizen of What Country?
USA | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collage (14 or 5+) 4+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Management Consultant | | 16b. Kind of Business/Industry
Self Employed | | 17. Father's Name (First, Middle, Last)
Alberto Otto | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Grace Reed | | 19a. Informant's Name/Relationship (Type, Print)
Mary K. Otto (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1009 Potomac Dr., Stafford, Va., 22554 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Northern Va. Crematory | | 20c. Location - City or Town, State
Arlington, Va. | | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Arlington Funeral Home
3901 N. Fairfax Dr., Arlington, Va., 22203 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)
August 15 2000 | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
National Navel Medical Center | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Bethesda, Md., 20889-5600 | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | |
| State Registrar | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year) | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gauiam S. Nayak, Lt, MC, USN | | 31. Data filed (Month, Day, Year)
AUG 30 2000 | |
| | 32. Registrar's Signature
 | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27479

| | | | | | | | | | | | | |
|---|---|---|---|-------------------------------|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Virginia E. Peregoy | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | | | 3. Time of Death
1:00pm | | | |
| | 4a. Facility Name (If not institution, give street and number)
1024 Johnsville Road | | | | 4b. City, Town, or Location of Death
Sykesville | | | | 4c. County of Death
Carroll | | | |
| Funeral
Director | 5. Social Security Number
214-52-9716 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 13, 1917 | | 9. Birthplace (State or Foreign Country)
Virginia | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1024 Johnsville Road | | | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waitress | | | 16b. Kind of Business/Industry
Food Service | | | | |
| | 17. Father's Name (First, Middle, Last)
Robert Carrey Harvey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Susan Denton | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mr. James Blaney (Personal Rep) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1036 Circle Drive Sykesville, MD 21784 | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park | | Date
8/15/2000 | | 20c. Location - City or Town, State
Sykesville, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
Brian L. Haight | | | | 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
One hour | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
MD | | | | 29c. License number
D33184 | | | | 29d. Date signed (Month, Day, Year)
August 14, 2000 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jonathan Kushner 114 Business Center Drive Reisterstown, MD 21136 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
Benita B. Sparks | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27480

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
Angiolina Pompa | | | | 2. Date of Death
Month August Day 12 Year 2000 | | | | 3. Time of Death
1:50 PM | | | | | |
| 4a. Facility Name (If not institution, give street and number)
Sligo Creek Nursing Home & Rehab. | | | | 4b. City, Town, or Location of Death
Takoma Park | | | | 4c. County of Death
Montgomery | | | | | |
| 5. Social Security Number
214-74-0576 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
100 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
Dec. 13, 1899 | | 9. Birthplace (State or Foreign Country)
Italy | |
| Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Takoma Park | | | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
7525 Carroll Avenue | | | | | | 10f. Zip Code
20912 | | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | | |
| 17. Father's Name (First, Middle, Last)
Francesco Maiatico | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Teresa Donatelli | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Grace Quattrone / Daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1420 Ray Road, Hyattsville, Maryland 20782 | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | | | Date
08/16/00 | | 20c. Location - City or Town, State
Brentwood, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal Bleeding
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | | | Approximate Interval Between Onset and Death
Days | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier

MD | | | | 29c. License number
D08089 | | 29d. Date signed (Month, Day, Year)
August 14, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Leibowitz, M.D. 11120 New Hampshire Ave., Silver Spring, Maryland 20904 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | | | 32. Registrar's Signature

B. Sparks | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27481

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SAMUEL

PERRY

2. Date of Death

Month Day Year
AUGUST 7, 2000

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

HAVEN HOUSE NURSING HOME

4b. City, Town, or Location of Death

POTOMAC

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

192-14-4077

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUGUST, 20, 1915

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

POTOMAC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

11834 GOYA DRIVE

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

ISAAC PERRY

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE LEVY

19a. Informant's Name/Relationship (Type, Print)

IRIS J. BENJAMIN NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 316 MONKTON MD. 21111

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

AUGUST

11, 2000

20c. Location - City or Town, State

OLNEY, MD.

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY GOLDBERG MEMORIAL CHAPELS INC.
1170 ROCKVILLE PIKE ROCKVILLE, MD. 20854

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. MYOCARDIAL INFARCT

Due to (or as a consequence of):

HYPERTENSION

b.

Due to (or as a consequence of):

DIABETES

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST HIP FRACTURE, CHRONIC OBSTRUCTIVE
PULMONARY DISEASE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wavell C. Hodge

29c. License number

D31383 MD

29d. Date signed (Month, Day, Year)

AUGUST 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAVELL C. HODGE, M.D., 50 IRVING STREET NW, WASHINGTON, DC 20422

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27482

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Inez G. Perry

2. Date of Death

Aug 10 2000

3. Time of Death

3pm

4a. Facility Name (If not institution, give street and number)

12223 Centerhill Street

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

226-24-2898

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 15, 1924

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12223 Centerhill Street

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Benjamin Weston Gilbert

18. Mother's Name (First, Middle, Maiden Surname)

Willie Blanche Dulaney

19a. Informant's Name/Relationship (Type, Print)

James T. Perry/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 225, Ashton, MD, 20861

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

8/15/00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Tracy A. Stover

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd W
Silver Spring MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Terminal

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George F. Sengstack MD

29c. License number

D12121

29d. Date signed (Month, Day, Year)

8/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George F. Sengstack MD, 3929 Ferrara Dr. Wheaton, MD 20906

State
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Brena B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27483

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Miguel Jacinto Perez

2. Date of Death

Month 8 Day 13 Year 2000

3. Time of Death

10:25 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-27-2557

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep 27, 1961

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Lewisdale

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

7106 24th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☒ Yes ☐ No Specify: Mexican14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bricklayer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jose C. Perez Garcia

18. Mother's Name (First, Middle, Maiden Surname)

Juana Guzman

19a. Informant's Name/Relationship (Type, Print)

Teresa Perez / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7106 24th Avenue, Lewisdale, MD 20783

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

8/14/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home
500 University Blvd. W
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pseudomonas Pneumonia

Due to (or as a consequence of):

10 Days

b. Cystic Lung Disease

Due to (or as a consequence of):

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0045121

29d. Date signed (Month, Day, Year)

8/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Reagan, MD
Kaiser Permanente, Holy Cross Hospital 1500 Forest Glen Ave. Silver Spring MDState
Registrar

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27484

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Diane F. Pedersen

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

16400 Kipling Road

4b. City, Town, or Location of Death

Derwood

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

398-34-9747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 3, 1937

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16400 Kipling Road

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Keller

18. Mother's Name (First, Middle, Maiden Summa)

Lucille (not available)

19a. Informant's Name/Relationship (Type, Print)

Ole A. Pedersen/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16400 Kipling Road, Derwood, Maryland 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Data

Aug. 16, 2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrhythmia

Due to (or as a consequence of):

Congestive Heart Failure

Approximate Interval Between Onset and Death

1 1/2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dementia

Due to (or as a consequence of):

Hypertension

3-4 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40970

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ceri Yen-Kan, M.D. 501 North Frederick Ave., Gaithersburg, Maryland 20877

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

00 27485

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Ottis Lee Roebuck, Sr. | | 2. Date of Death
Month Day Year
August 12 2000 | | 3. Time of Death
02:10 P.M. | |
| 4a. Facility Name (If not institution, give street and number)
555 Ridge Road | | 4b. City, Town, or Location of Death
Westminster | | 4c. County of Death
Carroll | |
| 5. Social Security Number
216-52-6923 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | 8. Date of Birth (Month, Day, Year)
June 5, 1951 | 9. Birthplace (State or Foreign Country)
North Carolina | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | 10b. County
Carroll | 10c. City, Town or Location
Westminster | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
555 Ridge Road | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
General Nursing Aid | | 16b. Kind of Business/Industry
Health Care | | | |
| 17. Father's Name (First, Middle, Last)
Joseph LeRoy Roebuck | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nannie Wilson | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Nannie Roebuck (Mother) | | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
6614 Freedom Avenue Sykesville, MD 21784 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park | | 20c. Location - City or Town, State
8/16/2000 Sykesville, MD | |
| 21. Signature of Funeral Service Licensee
Brian D. Haight | | 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
J. M. Titus | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
August 13, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature
[Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27486

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie F. Robinson

2. Date of Death

Month August Day 12 Year 2000

3. Time of Death

1:25 a.m.

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice-Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

223-12-2272

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Jan. 27, 1922

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2903 Collins Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William McKinley Farmer

18. Mother's Name (First, Middle, Maiden Surname)

Earlie Mobley

19a. Informant's Name/Relationship (Type, Print)

Michael W. Robinson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1117 Lewis Avenue, Rockville, MD 20851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

August 12, 2000

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

J. Ken Skile

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Idiopathic Pulmonary Fibrosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark S. Godec, MD

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

8/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Godec, MD, Casey House, 6001 Muncaster Mill Road Rockville, MD 20855

State
Registrar

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27487

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John N. Reichert

2. Date of Death

Month
AugDay
16Year
2000

3. Time of Death

1:50 AM

4a. Facility Name (If not institution, give street and number)

Manor Care - Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

172-01-2225

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
Nov 26, 1908

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 Indian Spring Drive

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Telecommunications

17. Father's Name (First, Middle, Last)

John A. Reichert

18. Mother's Name (First, Middle, Maiden Surname)

Addie Seibert Green

19a. Informant's Name/Relationship (Type, Print)

John N. Reichert/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11254 Oakton Rd, Oakton, VA 22124

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

8/19/00

20c. Location - City or Town, State

Churchtown, PA

21. Signature of Funeral Service Licensee

Tracy A. Shaver

22. Name and Address of Facility Francis J. Collins Funeral Home

500 University Blvd. W.
Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerosis

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joel R. Schuman

29c. License number

D20516

29d. Date signed (Month, Day, Year)

8/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9410 OLD GEORGETOWN RD Bethesda, MARYLAND 20814

State
Registrar

31. Date filed (Month, Day, Year)

AUG 17 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27488

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | | | | | |
|---|--|---|---|--|-----------------------------------|--|--|--|-----------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)
Mirta G. Ramos - Izquierdo | | | | | | 2. Date of Death
Month Day Year
August 15 2000 | | | 3. Time of Death
12:25 AM | | |
| 4a. Facility Name (If not institution, give street and number)
Holy Cross Rehab. Nursing Center | | | | | | 4b. City, Town, or Location of Death
Silver Spring | | | 4c. County of Death
Montgomery | | |
| 5. Social Security Number
220-60-4556 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | 8. If Under 1 Year
Months Days | 9. If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 12, 1908 | | 9. Birthplace (State or Foreign Country)
Cuba | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
13904 Pleasant Grove Court | | | | 10f. Zip Code
20904 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Cuban | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
Ramiro Guera | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Laudelina De Ben | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Antonio Ramos-Izquierdo / Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13904 Pleasant Grove Ct., Silver Spring, MD 20904 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Our Lady of Mercy Cem. 08/18/00 | | 20c. Location - City or Town, State
Miami, Florida | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. Cardiopulmonary arrest
Due to (or as a consequence of):</p> <p>b. Congestive heart failure
Due to (or as a consequence of):</p> <p>c. Pneumonia
Due to (or as a consequence of):</p> <p>d. Myelodysplastic Syndrome
Due to (or as a consequence of):</p> </div> </div> | | | | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | | | 29c. License number
D37801 | | 29d. Date signed (Month, Day, Year)
August 15, 2000 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. Seidman, M.D. 11906 Darnestown Rd., North Potomac, Maryland 20855 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 17 2000 | | 32. Registrar's Signature
 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27489

| | | | | | | | | |
|--|--|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Carlton Howell Shamer Sr | | | | 2. Date of Death
Month Day Year
Aug 14 2000 | | 3. Time of Death
7:30 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
2710 Patapsco Road | | | | 4b. City, Town, or Location of Death
Finksburg | | 4c. County of Death
Carroll | |
| Funeral
Director | 5. Social Security Number
215-32-5965 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
65 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jun 16 1935 | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Finksburg | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2710 Patapsco Road | | 10f. Zip Code
21048 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Owner/Operator | | 16b. Kind of Business/Industry
Shamers Used Parts | | | | |
| 17. Father's Name (First, Middle, Last)
Howell E. Shamer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ellie (Unknown) | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty Shamer/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2710 Patapsco Rd Finksburg, MD 21048 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Patapsco Cemetery | | 20c. Date
8/17 | | 20d. Location - City or Town, State
Finksburg, MD | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Pritts Funeral Home and Chapel
412 Washington Rd Westminster, MD 21157 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ALCOHOLIC CARDIOMYOPATHY
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Thomas K. Galvin III MD | | | | 29c. License number
D31660 | | 29d. Date signed (Month, Day, Year)
8/15/2000 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS K. GALVIN III MD. 295 STONE AVE WESTMINSTER MD 21157 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27490

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Isabelle Yeates Sheldon | | 2. Date of Death
Month August Day 11 Year 2000 | | 3. Time of Death
9:25pm | |
| 4a. Facility Name (If not institution, give street and number)
Casey House | | | 4b. City, Town, or Location of Death
Rockville | | 4c. County of Death
Montgomery |
| 5. Social Security Number
022-12-3983 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct 2 1919 |
| 9. Birthplace (State or Foreign Country)
Massachusetts | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Md | 10b. County
Montgomery | | 10c. City, Town or Location
Potomac | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
7704 Hackamore Drive | | 10f. Zip Code
20854 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (14 or 5+) +4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
doscent | | 16b. Kind of Business/Industry
cultural arts | |
| 17. Father's Name (First, Middle, Last)
Percival Ernest Yeates | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosabelle F. Azniv | | |
| 19a. Informant's Name/Relationship (Type, Print)
Courtney R. Sheldon (spouse) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7704 Hackamore Dr., Potomac, MD 20854 | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation | | 20c. Location - City or Town, State
8-13-2000 Sykesville, Md | |
| 21. Signature of Funeral Service Licensee
Phige Haight Herbert | | | 22. Name and Address of Facility
Haight Funeral Home & Chapel
P.O. Box 195 Sykesville, Md 21784 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. metastatic ovarian carcinoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death
9 mos. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Mark S. Godec, MD | | 29c. License number
D0037620 | | 29d. Date signed (Month, Day, Year)
8-12-2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark S. Godec, M.D. Casey House, 6001 Muncaster Mill Rd., Rockville, Md 20855 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
[Signature] | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27491

Funeral Director

Physician
/Medical
Examiner

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)
Frank Strohkarck | | | | | | 2. Date of Death
Month August Day 12 , Year 2000 | | 3. Time of Death
2:50am | |
| 4a. Facility Name (If not institution, give street and number)
Fairhaven Health Care Center | | | | | | 4b. City, Town, or Location of Death
Sykesville | | 4c. County of Death
Carroll | |
| 5. Social Security Number
322-16-5025 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| 8. Date of Birth (Month, Day, Year)
NOV 19, 1908 | | 9. Birthplace (State or Foreign Country)
Iowa | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. Street and Number
7200 Third Avenue | | | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
6 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Vice- President | | | 16b. Kind of Business/Industry
Publishing Company | | |
| 17. Father's Name (First, Middle, Last)
Frank Strohkarck | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Amanda Moldenscheidt | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mr. Alan Hunt (Executor) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 26 Chincoteague, VA 23336 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation Ser | | Date
8/15/00 | | 20c. Location - City or Town, State
Sykesville, MD | |
| 21. Signature of Funeral Service Licensee
Brian L. Haight | | | | 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 | | | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular disease
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
years |
| b. Due to (or as a consequence of): | | |
| c. Due to (or as a consequence of): | | |
| d. Due to (or as a consequence of): | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

asthmatic bronchitis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

| | | | | | |
|--|--|---|--|---|--|
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
Ellis Mez MD | | 29c. License number
D22220 | | 29d. Date signed (Month, Day, Year)
August 11, 2000 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ellis Mez MD 1645 Liberty Road Eldersburg, MD 21784 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 15 2000 | | 32. Registrar's Signature
B. Sparks | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

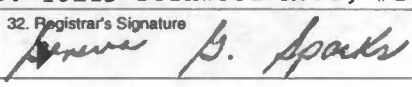
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27492

| | | | | | | | | | | |
|--|---|--|--|--|---|---|--------------------------------|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Richard Paul Striker | | | | | 2. Date of Death
Month Day Year
August 13, 2000 | | | 3. Time of Death
9:28 PM | |
| | 4a. Facility Name (If not institution, give street and number)
5601 Greentree Road | | | | | 4b. City, Town, or Location of Death
Bethesda | | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
197-30-9720 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
July 1, 1940 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 10e. Street and Number
5601 Greentree Road | | | | | | | | | | |
| 10f. Zip Code
20817 | | | | | | | | | | |
| 10g. Citizen of What Country?
United States | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1963-
If Yes, Give Year or Dates: 1971 | | | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4 or 5+) 5+ | | | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Administrative Officer | | | | | | | | | | |
| 16b. Kind of Business/Industry
National Institutes of Health | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Alex Striker | | | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Vliga Simko | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Kimberly J. Striker/Daughter | | | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5505 Hoover Street, Bethesda, Maryland 20817 | | | | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery | | | | | | | | | | |
| 20c. Location - City or Town, State
Silver Spring, Maryland | | | | | | | | | | |
| 20d. Date
August 18, 2000 | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 00689 | | | | | | | | | | |
| 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,
Bethesda, Maryland 20814-3501 | | | | | | | | | | |
| 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line. | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
a. <u>Cardiac Arrest</u> | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| b. <u>Coronary Disease</u> | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| c. <u>Cigarette Smoking</u> | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | |
| d. | | | | | | | | | | |
| Approximate Interval Between Onset and Death
Immediate
years
years | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Alcoholism, Pancreatic insufficiency,</u>
<u>Carcinoma of Prostate</u> | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 M.D. | | | | | | | | | | |
| 29c. License number
D21115 | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
August 14, 2000 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lee R. Pennington, M.D. 10215 Fernwood Road, #100, Bethesda, Maryland 20817 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

30 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27493

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STANLEY JOSEPH SHULTZ

2. Date of Death

Month Day Year
August 11, 2000

3. Time of Death

2:15pm

4a. Facility Name (If not institution, give street and number)

5901 Montrose Rd. #704 North

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

016-14-0004

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 2, 1917

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5901 Montrose Road, #704 North

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Officer

16b. Kind of Business/Industry

Central Intelligence Agency

17. Father's Name (First, Middle, Last)

Adam

Shultz

18. Mother's Name (First, Middle, Maiden Surname)

Isabella

Unknown

19a. Informant's Name/Relationship (Type, Print)

Isabel R. Shultz, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5901 Montrose Road, #704 N, Rockville, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

Aug 12, 2000

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ARRHYTHMIA

Due to (or as a consequence of):

b.

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

MINUTES

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

T. J. Anthony, M.D.

29c. License number

D 50300

29d. Date signed (Month, Day, Year)

August 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS J ANTHONY, MD, 9801 GEORGIA AVE, #116, SILVER SPRING, MD 20902

31. Date filed (Month, Day, Year)

AUG 15 2000

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27494

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Ruth Seifert

2. Date of Death

August 16, 2000

3. Time of Death

7:08A.

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

214-01-8264

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3205 Dunnington Road

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William George

Gorsch

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Mahrer

19a. Informant's Name/Relationship (Type, Print)

John R. Seifert, Sr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory 8/17/2000 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Cardiac Failure

a. Due to (or as a consequence of):

Septic Shock

b. Due to (or as a consequence of):

Staph Aureus

c. Due to (or as a consequence of):

Probable Endocarditis

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Pancreatitis

Respiratory Failure

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Yung S. Pang

29c. License number

D55213

29d. Date signed (Month, Day, Year)

August 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yung S. Pang, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910

State
Registrar

31. Date filed (Month, Day, Year)

AUG 18 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27495

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LILLIAN VIRGINIA SOMERS | | | | 2. Date of Death
Month Day Year
August 11, 2000 | | 3. Time of Death
0531 | |
| | 4a. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO | |
| Funeral
Director | 5. Social Security Number
215-36-0776 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
66 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 8, 1934 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Somerset | | 10c. City, Town or Location
Princess Anne | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
30380 Maple Street | | | | 10f. Zip Code
21853 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 11 College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Worker | | 16b. Kind of Business/Industry
Seafood | | |
| 17. Father's Name (First, Middle, Last)
William H. Webster | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mollie V. Abbott | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joyce Ann Anderson (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30572 Pine Knoll Drive - Princess Anne, MD 21853 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Church Cemetery | | Date
8/13/00 | | 20c. Location - City or Town, State
Deal Island, MD | | |
| 21. Signature of Funeral Service Licensee

Robert H. Bradshaw, Jr. | | | | 22. Name and Address of Facility
Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 21817 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End stage lung disease
Due to (or as a consequence of):
b. COPD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Lung cancer | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Lung cancer | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier

Christopher Huddleston | | | | 29c. License number
029105 | | 29d. Date signed (Month, Day, Year)
8/11/00 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christopher Huddleston, M.D. 106 Military St. Salisbury, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | 32. Registrar's Signature

Geneva B. Sparks | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIDNEY W. SMITH, JR.

2. Date of Death

August 10, 2000

3. Time of Death

1:05 P.M.

4a. Facility Name (If not institution, give street and number)

4760 Poplar Street

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral
Director

5. Social Security Number

721-07-6048

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 26, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4760 Poplar Street

10f. Zip Code

21817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No W. W.
If Yes, Give
Year or Dates: II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
(11) (Graduate)College (1-4or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Stationary Engineer

16b. Kind of Business/Industry

Institutional

17. Father's Name (First, Middle, Last)

Sidney W. Smith

18. Mother's Name (First, Middle, Maiden Sumama)

Mary Rankin

19a. Informant's Name/Relationship (Type, Print)

Eleanor T. Smith (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4760 Poplar Street - Crisfield, MD 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

George Washington Memorial Park

Date

8/14/00

20c. Location - City or Town, State

Paramus, N. J.

21. Signature of Funeral Service Licentiate

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home
306 W. Main St. - Crisfield, MD 2181723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC COLON CANCER

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 48098

29d. Date signed (Month, Day, Year)

8/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

31. Date filed (Month, Day, Year)

AUG 14 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27497

amend item 26 per phys. G786 8/30/00 yf

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|-------------------------------|--|---|--|--|---|---|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Shirley Mae Schaubert | | | | 2. Date of Death
Month Day Year
July 27 2000 | | 3. Time of Death
6:45AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
708 Truslow Road | | | | 4b. City, Town, or Location of Death
Chestertown | | 4c. County of Death
Queen Anne's | | | |
| Funeral
Director | 5. Social Security Number
195-26-1680 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
October 5, 1934 | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
FL | | 10b. County
Sarasota | | 10c. City, Town or Location
Nokomis | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
339 Desoto St | | | | 10f. Zip Code
34275 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurse | | | 16b. Kind of Business/Industry
Health Care | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Arthur C. Ansorg | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy M. Winters | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Adam B. Schaubert, Jr. / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
339 Desoto St, Nokomis FL 34275 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation Cent | | 20c. Date
7/28/2000 | | 20d. Location - City or Town, State
Stevensville, MD | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home P.A.
130 Speer Rd, Chestertown MD 21620 | | | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Respiratory Arrest
Due to (or as a consequence of):
COPD (severe)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)
if immediate years | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) relative residence | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
200005754 | | 29d. Date signed (Month, Day, Year)
7-28-00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ralph Libby, 204 Medical Center Road, Grasonville, MD 21638 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JUL 28 2000 | | 32. Registrar's Signature
 | | | | | | | | |

5000 5 JUL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27498

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Margaret Truman

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

6:35 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

036-01-3444

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 30, 1914

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11436 Frances Green Drive

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Goyette

18. Mother's Name (First, Middle, Maiden Surname)

Violet Smith

19a. Informant's Name/Relationship (Type, Print)

Elaine F. Truman/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11436 Frances Green Dr., North Potomac, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Francis Cemetery

Date

Aug. 21,
2000

20c. Location - City or Town, State

Pawtucket, Rhode Island

21. Signature of Funeral Service licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urosepsis

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 47791

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A. Holden, M.D.
809 Veirs Mill Rd Rockville, MD 20851State
Registrar

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

8-14-00 6:35 AM
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 22a or 22a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Truman, Edna

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 27499

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILMA MARIE TOFFLER | | | | 2. Date of Death
Month Day Year
AUG 14 2000 | | 3. Time of Death
8:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | | |
| Funeral
Director | 5. Social Security Number
562-26-3053 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
78 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
10-05-1921 | | 9. Birthplace (State or Foreign Country)
CA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Prince Georges | 10c. City, Town or Location
Temple Hills | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
3914 23rd Place | | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
High School Teacher | | 16b. Kind of Business/Industry
Public School | | | | |
| | 17. Father's Name (First, Middle, Last)
John S. Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nellie LeClair | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Hermann A. Toffler -Husband | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
547 Florida Ave #104 Herndon, VA 20170 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 8-17-00 Alexandria, VA | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
Chris Adams | | | 22. Name and Address of Facility
Adams-Green Funeral Home
721 Elden Street Herndon, VA 20170 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ENDOCARDITIS
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
C.C.McMonigle MD | | | 29c. License number
40812-020 (WI) | | 29d. Date signed (Month, Day, Year)
8/14/00 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C.C.McMONIGLE, LT, MC, USNR | | | NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600 | | | | | |
| 31. Date filed (Month, Day, Year)
AUG 16 2000 | | | 32. Registrar's Signature
B. Sparks | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 27500

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Owen Thorpe

2. Date of Death

Month Day Year
August 14, 2000

3. Time of Death

3:55 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Wilson Health Care and Rehabilitation Ctr.

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

204 12 3213

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 1, 1908

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

403 Russell Ave. #110

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurseryman

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Matti Torppa

18. Mother's Name (First, Middle, Maiden Surname)

Vera L. Lenonen

19a. Informant's Name/Relationship (Type, Print)

Louise Crissman / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7708 Maryknoll Ave., Bethesda, MD 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory Inc 2000

Date

Aug. 16

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kapp Funeral and Cremation Services
Stephen D. Lohrmann P.A.
933 Gist Ave., Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Left Hemispheric Stroke

Due to (or as a consequence of):

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral atrophy; Alzheimer's Disease;

Periventricular White Matter disease; Hypertension

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury of
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D04115

29d. Date signed (Month, Day, Year)

August 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robert Birschbach M.D., 6320 Democracy Blvd., Bethesda, MD 20817

31. Date filed (Month, Day, Year)

AUG 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

10

